GUILFORD COUNSELING, PLLC
(336) 337-5469
430 BATTLEGROUND AVE GREENSBORO NC

Adult & Adolescent Intake Interview

CLIENT INFORMATION

First Name | Middle | Last | Date Completed (MM/DD/YYYY)

Gender
☐ Female ☐ Male

Date of Birth (MM/DD/YYYY)

How Were You Referred?

☐ Google Search ☐ Psychology Today ☐ Other Professional

Referrer's Name

☐ Other

Other Referrer

Completed By (If Not Client)

Phone

Relationship

Primary Reason For Appointment

PERSONAL HISTORY

Following are questions regarding your personal history. The purpose of this form is to gather initial background information in order to save time in your first session. Please feel free to skip questions that do not apply to your particular situation or that you are not comfortable answering. Please note that the more information you share, the more complete picture your counselor will have of your situation. You will have an opportunity in your first session to provide more details and ask questions about this form.

Have you ever attended Counseling/Therapy Before? ☐ Yes ☐ No If so, with whom?

Details (When, How Long, etc.):

Are you a current patient of a Psychiatrist? ☐ Yes ☐ No If so, Who?

Have you ever attempted suicide or had a plan to harm yourself? ☐ Yes ☐ No If so, When?

Details:

Do you currently have any thoughts and/or feelings of wanting to physically harm yourself? ☐ Yes ☐ No

If so, please explain:

Have you, in the past, or are you currently under treatment for substance abuse? ☐ Past ☐ Current ☐ N/A

If so, please explain:

Are you a survivor of any of the following forms of abuse? ☐ Emotional ☐ Physical ☐ Sexual

If so, please explain:

Have you ever received a formal diagnosis from a mental health professional? ☐ Yes ☐ No

If so, please explain:

Is there any history of mental disorders/illness in your family? ☐ Yes ☐ No

If so, please explain:

MEDICATIONS (Please note medications you are currently taking)

Medication	Dose	Start Date	Who Prescribes?	Purpose

Is there anything else we should know about your medication(s) (i.e. other prescriptions, supplements, side effects, etc.)

RELATIONSHIPS (Please note any significant family members, relationship partners, friends, etc.)

First Name	Relationship	Age	Live With?	Notes
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	
			☐ Yes	

How do you typically relate to other people (Check all that apply):

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/Argue Often ☐ Follower ☐ Friendly ☐ Leader

☐ Outgoing ☐ Shy/Withdrawn ☐ Submissive

☐ Other (Please Explain)

EDUCATION

Please check any of the following that apply:

☐ High School Grad/GED ☐ Vocational School ☐ College ☐ Grad School ☐ Other

Please note any other significant educational information (degrees obtained, learning disabilities, special trainings, current plans, etc.)

EMPLOYMENT

Please check any that apply: ☐ Part-Time ☐ Full-Time ☐ Contractor ☐ Self-Employed ☐ Stay At Home Parent ☐ Retired

Employer: Position: How Long?

CULTURE/ETHNICITY

With which cultural or ethnic group(s), if any, do you identify?

Please describe any issues/challenges you are experiencing due to cultural or ethnic issues:

SPIRITUALITY/RELIGION

How important to you are spiritual/religious matters? ☐ Not ☐ Minor ☐ Moderately ☐ Very

Are you affiliated with a spiritual/religious group? ☐ Yes ☐ No If Yes, describe:

Were you raised in a spiritual/religious group? ☐ Yes ☐ No If Yes, describe:

Please share any other important thoughts/notes about spirituality/religion you feel it important that your counselor understand:

LEGAL

Are you involved in any active legal cases (traffic, civil, criminal)? ☐ Yes ☐ No

If so, please explain:

Are you presently on probation or parole? ☐ Yes ☐ No

If so, please explain:

Please share any other important current or past legal history you feel it is important that your counselor be aware of:

LEISURE/RECREATION

Please describe any leisure/recreational/hobby activities that you engage in.

Activity	How Often Now?	How Often In the Past?

NUTRITION

How would you rate the quality of your nutrition/diet/eating habits?

☐ Poor ☐ Could Use Improvement ☐ Adequate ☐ Above Average ☐ Excellent

Please share any food/nutrition related thoughts/issues/challenges you feel your counselor should be aware of:

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MEDICAL

How would you rate your current overall physical health?

☐ Poor ☐ Could Use Improvement ☐ Adequate ☐ Above Average ☐ Excellent

Please describe any current health concerns and/or recent changes in your health:

Please describe any family history of medical problems:

Please check if there have been any recent changes in the following:

☐ Sleep ☐ Eating/Diet ☐ Behavior ☐ Energy Level ☐ Physical Activity ☐ General Mood ☐ Weight ☐ Stress

Please describe any changes you checked above:

Do you drink alcohol? ☐ Yes ☐ No If so, how often?

Do you smoke? ☐ Yes ☐ No If so, how often?

SYMPTOM CHECKLIST

Please check any of the following that you feel apply to you (on a regular basis):

☐ Aggressive	☐ Disturbing Thoughts	☐ Impulsive	☐ Poor Concentration
☐ Alcohol Dependency	☐ Dizziness	☐ Incompetent	☐ Recurring Thoughts
☐ Angry	☐ Drug Dependence	☐ Inferior	☐ Regrets for Past
☐ Anti-Social	☐ Elevated Mood	☐ Internet Addiction	☐ Restless
☐ Anxious	☐ Empty Feelings	☐ Irritable	☐ Sexual Addiction
☐ Avoid People	☐ Evil	☐ Judgement Errors	☐ Sexual Difficulties
☐ Bad Home Environment	☐ Fatigue	☐ Lonely	☐ Sick Often
☐ Bored	☐ Financial Problems	☐ Memory Problems	☐ Sleep Problems
☐ Cannot Make Decisions	☐ Gambling Problem	☐ Misunderstood	☐ Speech Problems
☐ Confused	☐ Guilty	☐ Mood Swings	☐ Thoughts of Self Harm
☐ Controlling	☐ Hallucinations	☐ Nightmares	☐ Trembling
☐ Depressed	☐ Hateful	☐ Not Confident	☐ Unattractive
☐ Disorganized Thoughts	☐ Headaches	☐ Not Loved	☐ Withdrawing
☐ Disorientation	☐ Heart Palpitations	☐ Panic Attacks	☐ Worrying
☐ Distractible	☐ Hopelessness	☐ Phobias/Fears	☐ Worthless

Please list your strengths and positive influences in your life:

Please describe your goals for counseling / things you would like to change about your life: