Threshold Counseling and Coaching, LLC

Adult Counseling Intake Form

Note: This information may be confidential; however certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better Threshold Counseling and Coaching, LLC is able to meet your specific needs.

Demographic Information:

Name: ____ Date: __________________

Date of Birth (DOB): ___________________________________ Gender: ________________

Age: ____ **Relationship Status:** *Single Married Divorced Separated Widowed Other:* ____

Mobile Phone: ____________________ *Is it okay to leave a message for you at this number?* ***Y or N***

Home Phone: ____________________ *Is it okay to leave a message for you at this number?* ***Y or N***

Work Phone: ____________________ *Is it okay to leave a message for you at this number?* ***Y or N***

Email: ____ *Is it okay to email you?* ***Y or N***

Mailing Address: ____

Current Employer: ____

Is your primary insurance Medicaid? ***Y or N***

Emergency Contact: _________________________ Phone Number:_____________________

Relationship: _________________________ Who referred you?: _______________________

Preferred mode of communication: email or phone (voice) or phone (text)

*Please review the Threshold Counseling and Coaching's HIPAA and Notice of Privacy Policies and Consent for Communication by Non-Secure Transmissions before agreeing to receive communication via electronic means.

Current Concerns:

Please describe why you are seeking counseling and any issues/problems that led you to seek counseling.

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In the past, what has been helpful for you in dealing with this problem?

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Among your friends and family, on whom do you count for support (spiritual, emotional, financial, etc.)?

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Do you smoke?

Tobacco: YES NO At what age did you start? ____________________

Marijuana: YES NO At what age did you start? ____________________

Do you use drugs? YES NO At what age did you start? ____________________

Drug(s) of choice? __________________________

Do you drink alcohol? YES NO How many drinks per week? __________________

Do you have other addictions (e.g. sex, gambling, etc.)? YES NO

Danger to Self or Others:

Have you ever had thoughts of harming yourself or others? YES NO If yes, please explain:

____

____

Have you ever seriously considered suicide or attempted suicide? YES NO If yes, please explain:

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Do you have the intent and means to die by suicide right now?

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____

Medical and Mental Health History:

Are you experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc.?
If yes, please explain:

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____

Are there any significant past or present **health or medical** issues that I should be aware of?

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____

Are there any significant past or present **mental health** issues that I should be aware of?

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Medications

If applicable, please list all the medications you are now taking and/or have taken in the past three months:

Medication:	*Dosage:*	*Prescriber:*	*How long have you been taking this?*	*Helpful? (Y/N)*

Name and phone number of physician*: ____

Name and phone number of psychiatrist* (if any): ____________________________________

Name and phone number of current or previous counselor* (if any): ______________________

____

*Please note: In accordance with applicable HIPAA and Colorado regulations, I will not contact your physician, psychiatrist, or counselor without your knowledge and consent.

Have you ever experienced abuse (emotional, physical, and/or sexual)? YES NO If yes, please describe (including dates and relationship to the abuser).

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Have you ever experienced other types of trauma? YES NO If yes, please describe (including dates and event).

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Have you ever experienced flashbacks concerning the abuse? YES NO If yes, how often?

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Family of Origin Information:

Describe your immediate family (e.g. parents, siblings, ages, etc.):

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____

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Does your family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? YES NO If yes, please explain:

Relationship Status

Describe your relationship with your current partner. Please include how long you have been together and/or married:

What are the strengths of your relationship?

What are the weaknesses of your relationship?

What do you like most about your partner?

What do you dislike about your partner or have a hard time tolerating?

Has there been any domestic violence in your relationship?

Children (Include biological, step, adopted, & foster).

Name:	***Age:***	***Gender:***	***Living with you?***

Sentence Completion:

Please complete the following sentences:

I came here today ____

My relationship is ____

I am really happy when ____

I feel mad when ____

Growing up in my family _______________________________________

If I could change one thing _____________________________________

Six months from now ____

Is there anything else I need to know to better assist you?

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Signatures:

______________________________ ______________

Client (please print) Date

______________________________ ______________

Client (signature) Date

______________________________ ______________

Counselor (signature) Date