

DELMORE COUNSELING, LLC

One Crosswoods Bldg · 100 East Campus View Blvd., Suite 155 · Columbus, Ohio 43235

Adult Client Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, please leave them blank.

Identifying Information

Name: _____ Date of Birth: _____ Age: _____
Gender: Male Female Race: _____ Height: _____ Weight: _____ (optional)
Hair Color: _____ Eye Color: _____

Behavioral Health

Why are you seeking counseling?

What issues or circumstances do you believe contribute to your problems?

How long has this problem persisted?

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Have you previously been involved in counseling? No Yes If yes, describe the reasons for counseling and who provided the counseling.

Counselor:

Reason:

Outcome:

List your strengths:

List your weaknesses:

Psychiatric Hospitalizations: None Past Current

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
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Behavioral Health Symptom Checklist

Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

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Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
					<input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Are you currently pregnant ? No Yes Are you an IV drug user? No Yes

Have you ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Have you ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Are you involved in any community self-help groups such as AA No Yes

Family History

Marital status: Single Married Divorced Separated Widowed
 Living with a Significant Other but Never Married

If married: how long have you been married? _____ Spouse's age: _____

Are there presently experiencing any serious marital conflicts

No Yes If yes, explain: _____

If you have ever been divorced: How many times were you previously married? _____

Date of divorce(s) _____

Prior to the divorce(s), how long were you married? _____

Reasons for divorce(s) _____

Living Situation: Own Home Parent's Home Relative's Home Homeless Group Home
 Residential Other _____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education
Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Briefly describe any problem areas that occur between you and people you live with:

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Medical History			
Physician Name: _____			
Address: _____			
Street & Number	City	State	Zip
Date of most recent physical exam: _____		By Whom: _____	
Results: _____			
Immunizations Check the immunizations for the following diseases: <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diphtheria <input type="checkbox"/> German Measles <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Polio <input type="checkbox"/> Small Pox <input type="checkbox"/> Tetanus			
Allergies: _____			
List any major illness and/or operations: _____			
Have you had any medical hospitalizations in the last three years <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, complete below:			
Hospital	City	Date	Reason
List any <i>current</i> physical concerns (e.g. high blood pressure, headaches, dizziness, etc.): _____			
List any <i>past</i> physical concerns: _____			
Have you ever had head trauma that resulted in loss of consciousness and/or required medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes			
What <u>medications</u> are you now taking? List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.			
Prescription/Over the Counter Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes		Out of Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown	Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		
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Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown	Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		
Do you think these medications help you feel better? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			
Please list PAST medication usage (Dosage, Approximate Dates of Compliance, Reason for Discontinuing): _____ _____ _____			
Do you use caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes from (coffee, tea, soda) _____ Daily Use _____ Do you use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes from (cigarettes, snuff) _____ Daily Use _____			
Describe your appetite? <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Average Appetite <input type="checkbox"/> Large Appetite			
Has your weight changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much? _____ <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss			
How much sleep do you get each night? _____ When you go to bed, how long does it take you to fall asleep? _____			
Do you awaken in the night and have difficulty returning to sleep? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you awaken before you plan to get up? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Has client had any of the following <u>symptoms in the past 60 days</u> ? Please check.			
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Seizures

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<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Tingling in Arms/Leg
<input type="checkbox"/> Confusion	<input type="checkbox"/> Falling	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tremors
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Vision Changes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Pulse Irregularity	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Other: _____			

Health History Questionnaire

Health History Questionnaire: Has the client **or any of the relatives (related by blood)** had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother/sister, aunts/uncles, cousins, children, etc.) in the comment section below.

Problem	Client			Family History	Comment (Indicate family member relationship to client)
	Now	Past	Never		
AIDS/HIV					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Eating Disorder					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					
Other					

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If the client has had any of the above, please write the problem, what treatment was received, and when:

Problem and Treatment Received:	When:
Problem and Treatment Received:	When:

Educational History

Highest Degree attained: <input type="checkbox"/> High School <input type="checkbox"/> Associate Degree/2yr tech <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Ph.D.			
Highest Academic Year completed: _____		Highest Vocational Year Completed: (if applicable) _____	
Type of school placement: <input type="checkbox"/> Regular <input type="checkbox"/> Special Education <input type="checkbox"/> Home-Schooled <input type="checkbox"/> Unknown			
Type of Special Education Placement: <input type="checkbox"/> None <input type="checkbox"/> Cognitive Disability <input type="checkbox"/> Emotional Disability <input type="checkbox"/> Learning Disability <input type="checkbox"/> Multiple Disabilities <input type="checkbox"/> Other: _____			
Did you have difficulties in school? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, please explain			
Do you have special communication needs? <input type="checkbox"/> TTD Device <input type="checkbox"/> Interpreter Services			

Employment History

Employment Status	
<input type="checkbox"/> Employed Full Time (30 or more hours) <input type="checkbox"/> Employed Part Time If part time, number of hours worked weekly _____ Job/Occupation: _____	
<input type="checkbox"/> Unemployed <input type="checkbox"/> Unemployed due to disability. Date Last Worked _____ If unemployed, do you want to work? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, what kind of work would you like to do? _____	
Current Employment	
Name of employer: _____	
Job Position: _____ How long have you been in his position _____	
Date Last Worked _____	
Have you been disciplined by your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had frequent tardiness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had frequent absences? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you satisfied with your job <input type="checkbox"/> Yes <input type="checkbox"/> No	

Military History

Are you currently in the military? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what branch? _____ How long? _____	
Rank: _____ What work did you do for the military? _____	
Have you recently been deployed to a combat zone? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, have you experienced any psychological or physical difficulties because of this deployment? <input type="checkbox"/> No <input type="checkbox"/> Yes explain? _____	
Have you ever been in the military? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what branch? _____ How long? _____	
Rank: _____ What work did you do for the military? _____	
When were you discharged? _____ Type of discharge: _____	
Have you ever been deployed to a combat zone? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when? _____ Have you experienced any psychological or physical difficulties because of this deployment? <input type="checkbox"/> No <input type="checkbox"/> Yes explain? _____	

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Interests and Community Involvement
What meaningful activities, including leisure and recreational activities to you engage in?
What community activities, including volunteer work are you involved in?
What religious or spiritual activities do you participate in?
List any cultural or family traditions you have?

Legal History
Do you have a Legal Guardian/Custodian? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Name: _____ Phone: _____
Civil Proceedings: _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____
Domestic Relations Court (Custody, Protective Services, Restraining Orders): _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____
Child Support Enforcement Orders: _____
Job and Family Service Involvement with Family: _____
Caseworker assigned to Family: _____ Phone: _____
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency): <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____
Current Legal Status: <input type="checkbox"/> None <input type="checkbox"/> Awaiting Charges <input type="checkbox"/> On Probation/Parole <input type="checkbox"/> Conditional Release <input type="checkbox"/> Outpatient Commitment <input type="checkbox"/> Incarcerated <input type="checkbox"/> Other: _____
Legal Charges: Juvenile <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Charge: _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____ <input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Charge: _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____
Legal Charges: Adult <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Charge: _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____ <input type="checkbox"/> Felony <input type="checkbox"/> Misdemeanor Charge: _____ <input type="checkbox"/> Current <input type="checkbox"/> Past When? _____
Incarcerations: From _____ To _____ Where _____ Conviction: _____ From _____ To _____ Where _____ Conviction: _____
Probation/Parole Officer: _____ Phone: _____

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart that is maintained at Delmore Counseling, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision and/or consultation that falls within the ethical guidelines of the Social Work, Counseling, and Psychiatry Boards.

CLIENT'S SIGNATURE _____ DATE _____

PARENT OR LEGAL GUARDIAN SIGNATURE _____ DATE _____