INTAKE INFORMATION

Client's Name_____ Date_____

Address_____ Home Phone (____)_____

_____ Work Phone (____)_____

Birth Date_____ Age_____ Occupation_____

Education_____ Referral Source_____

Marital History_____ Religion_____

Family (please circle the appropriate reference, If client is an adult fill in below only for your spouse)

Husband / Father Name_____ Wife / Mother Name_____

Birth Date_____ Age_____ Birth Date_____ Age_____

Marital History_____ Marital History_____

Education_____ Occupation_____ Education_____ Occupation_____

Address_____ Address_____

Home Phone (____)_____ Home Phone (____)_____

Work Phone (____)_____ Work Phone (____)_____

Others in Household

Name	Relationship	Age	Birth Date	Education

OVER ☞

Briefly State Your Current Problem: _____

_____

_____

_____

_____

_____

_____

Health Information:

Name of personal physician_____

Current Medical Problems:_____

_____Are these problems being treated?____

Please list any medication currently being taken and dosage:_____

_____

Have you seen a counselor, psychologist, or psychiatrist before?_____ If yes, who & when:_____

_____

Have you ever been hospitalized for an emotional or drug / alcohol problem?_____ If yes, where & When:_____

_____

Chemical Use History	Yes	No
Do you use Alcohol or Drugs?	☐	☐
Do you sometimes drink more than you had planned?	☐	☐
Have family or friends ever expressed concern about your use of alcohol?	☐	☐
Have you ever been arrested for alcohol related charges (e.g., DUI, public intoxication)?	☐	☐
Have you ever had episodes where you were unable to remember periods when you were drinking?	☐	☐
Have family or friends ever expressed concern over your use of drugs?	☐	☐
Have you ever been arrested for any offense involving drugs?	☐	☐
Have you ever been treated for drug abuse?	☐	☐
Have you ever overdosed on drugs accidentally?	☐	☐
Have you ever purposely overdosed on drugs?	☐	☐
Have any members of your family had problems with drugs or alcohol?	☐	☐

Risk Factors	Yes	No
Do you know anyone who has ever attempted suicide?	☐	☐
Have you, in the last year, ever considered suicide?	☐	☐
Have you ever attempted suicide?	☐	☐
Have your personal problems affected your job or school performance?	☐	☐
If yes, how?		
_____		
_____		
Have you ever been exposed to serious Trauma?	☐	☐
If yes, how?_____		
_____		

Name:_____ **Date:**_____

Briefly State Your Current Problem:_____

_____

_____

_____

_____

_____

Health Information:

Name of personal physician_____

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Have you ever overdosed on drugs accidentally?	☐	☐
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Have any members of your family had problems with drugs or alcohol?	☐	☐

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Have you ever been exposed to serious Trauma?	☐	☐
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Rev. 5/2002

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Fax (610) 841-4967

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains

(cont.)

- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

☐ _____

☐ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

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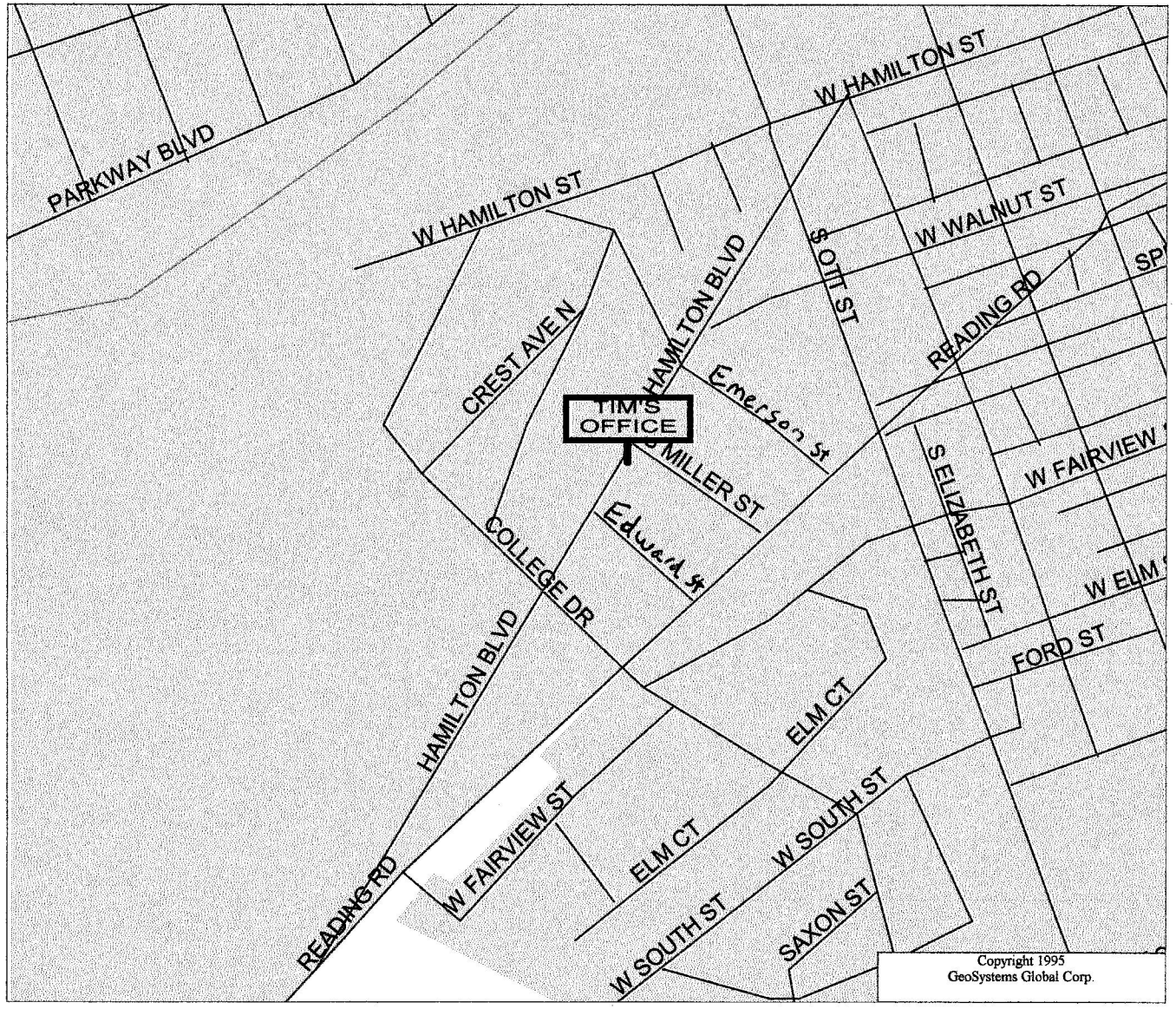
_____

S.W. corner of Hamilton & Miller Sts.

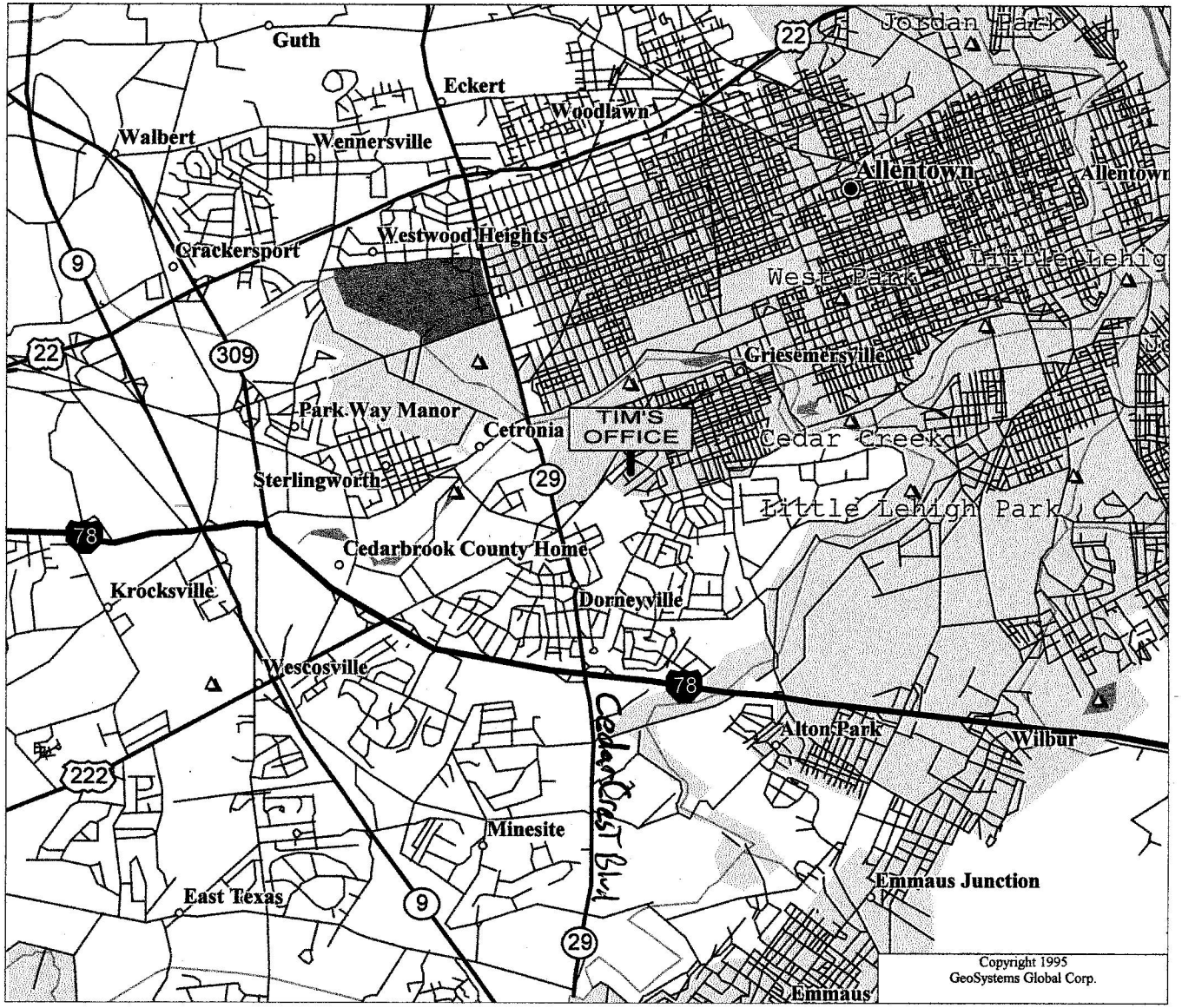


Please Park on Miller St.

Primary Road
Secondary Road
Minor Road
Park
Water
Built Up Area

0.11 mile

Tim's Office - 2806 Hamilton Blvd.



Primary Road
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Park
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1.0 mile

Compton's Complete Street Guide