GRACE
COUNSELING SERVICES

Adult Client Intake Form

Demographics

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

County: _____

It is customary GCS practice to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail at, please provide an alternate mailing address here:

_____

Phone: (H) _____ (C) _____ (W) _____

Email: _____ Method of contact: Phone or Email (circle one)

Age: _____ DOB: _____ Religious Affiliation: _____

Employer: _____ Occupation: _____

Marital Status: (circle one) Single Married (years married __) Divorced Widowed

Children: Below please include their names and ages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Referred by: _____

Previous Counseling

Previous Counseling? Yes No Who and When? _____

Release of information signed to talk with previous counselors? Yes No

Medical/Mental Health Information

What, if any, medical health problems do you have? _____

Physician _____ Current Medications _____

Are you on disability? _____ Please describe _____

Are you currently taking medication for a mental or emotional? _____

Please list conditions and medications: _____

_____

Have you ever been hospitalized for a mental or emotional condition? _____

If so, please list where and when: _____

_____

Do you currently use any alcohol or drugs?_____ If yes, what is your substance of choice?

_____

Are you in treatment? (such as outpatient) or utilizing support groups (such as AA)?_____

If yes, please describe: _____

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups -

_____

What are some of your hobbies/interests?_____

Reasons for seeking counseling:

_____

_____

_____

In a few words, what do you think therapy is all about?_____

_____

How long do you think therapy should last?_____ How long are you able to commit to therapy?_____

What personal qualities do you think the ideal therapist should possess?_____

_____

Emergency contact information: _____

Name: _____

Relationship: _____ Phone: _____

Client Signature: _____ Date: _____