HEADWATERS COUNSELING
201 W. Washington, STE 5, Zeeland, MI 49464
headwaterscounseling.net

ADULT INTAKE FORM

To help your clinician understand your concerns, please answer the following questions on this form.

Client's Legal Name:_____

Date of Birth: _____

What is your reason for seeking therapy today?

Gender Identity *(optional):* ◉ Male ○ Female ○ Transgender ○ Cisgender ○ Non-binary

Sexual Identity *(optional)*: ○ Heterosexual ○ Gay ○ Lesbian ○ Bisexual ○ Pansexual ○ Undecided

Undecided **Race/Ethnicity** *Please check all that apply (optional)*:

☐ African American ☐ Arab American ☐ Asian or Pacific Islander ☐ Caucasian

☐ Hispanic ☐ Multi-racial ☐ Native American ☐ Other:_____

DSM-5 SELF-RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – ADULT

None: Not at all **Slight**: Rare, less than a day or two **Mild**: Several days **Moderate**: More than half the days **Severe**: Nearly every day

	During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?	None	Slight	Mild	Moderate	Severe	Highest Domain Score
I	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting a lot more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, pipe, using snuff, or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Are there other concerns not listed above that you want to discuss?

PREVIOUS COUNSELING

Outpatient (place and year): ____

Inpatient (place and year):____

Intesive Outpatient Program/Partial (place and year): ________________________________

PREVIOUS & SUPPORTIVE RELATIONSHIPS

Martial Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Committed Partnership

Name	Age	Relationship (e.g. Spouse, Child, Friend, etc.)	Quality of Relationship	Living with you?
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No
			◯ Good ◯ Fair ◯ Poor	◯ Yes ◯ No

EDUCATION

Highest Level completed:

◯ High School ◯ Attended College or Technical School ◯ College Degree ◯ Graduate Degree

◯ Other_____

EMPLOYMENT/CAREER

◯ Employed ◯ Unemployed ◯ Disabled ◯ Retired ◯ Stay-at-Home Parent

FINANCES

Overall stress level: ◯ High ◯ Medium ◯ Low

SPIRITUALITY/RELIGIOUS BACKGROUND AND PRACTICE

Religious upbringing: ◯ Nonexistent ◯ Attending Church ◯ Belief in God ◯ Other _____

Present practice: ◯ Inactive ◯ Active ◯ Searching ◯ Other _____

TRAUMA HISTORY

Have you had a history of trauma, abuse, or neglect? ◯ Yes ◯ No

If yes, what type of abuse or trauma occurred? ◯ Physical ◯ Sexual ◯ Emotional ◯ Neglect ◯ Verbal

MEDICATIONS

Please list all current medications and supplements you are taking: (attach another page if needed, or bring a list to your appointment)

Name of Medication	Dosage/Amount	Frequency
	adf	

Have you had an allergic reaction to medication(s)? ◯ Yes ◯ No

Name of Medication: _____ Explain Reaction: _____

Name of Medication: _____ Explain Reaction: _____

MEDICAL INFORMATION (OPTIONAL)

Please check all medical issues for which you have had treatment:

- ☐ Allergies
  (e.g., allergic reactions, seasonal allergies, etc)
- ☐ Bone disease
  (e.g., osteoporosis, arthritis, broken bones, etc)
- ☐ Endocrine disease
  (e.g., diabetes, hypothyroid, low testosterone, etc)
- ☐ Head and brain illness or injury
  (e.g., fainting, concussion, seizures, dementia, etc)
- ☐ Immune disease
  (e.g., serious infections, Rheumatoid Arthritis, etc)
- ☐ Mouth and teeth disease
  (e.g., gum disease, cold sores, canker sores, etc)
- ☐ Poisoning & chemical exposure
  (e.g., overdose, lead exposure, work fumes, etc)
- ☐ Blood disease
  (e.g., anemia, bleeding disorders, etc)
- ☐ Digestive system disease
  (e.g., ulcers, heartburn, Celiac Disease, IBS, etc)
- ☐ Genetic disease
  (e.g., Sickle Cell, Fetal Alcohol, other syndromes, etc)
- ☐ Heart/cardiovascular disease
  (e.g., heart arrhythmia, heart attack, high blood pressure)
- ☐ Lungs and breathing disease
  (e.g., asthma, COPD, emphysema, etc)
- ☐ Muscle and movement disease
  (e.g., tremors, tics, Restless Legs, Parkinson's, etc)
- ☐ Serious injuries and wounds
  (e.g., burns, cuts, stabs, crushed limbs, etc)

Other:_____

*Check all areas where you have had past **surgeries:***

- ☐ Cancer
  (e.g., procedures for cancer treatment)
- ☐ Ear, Nose, Throat
  (e.g., tonsillectomy, thyroidectomy, etc)
- ☐ Obstetrics & Gynecology
  (e.g., hysterectomy, c-section, abortion, etc)
- ☐ Plastic surgery
  (e.g., reduction, implant, reconstruction, etc)
- ☐ Urology
  (e.g., kidney stones, hypospadias, etc)
- ☐ Weight loss
  (e.g., gastric bypass, band, sleeve, etc)
- ☐ Cardiac / Vascular
  (e.g., procedures for heart, blood clot, stroke)
- ☐ Gastroenterology (digestive system)
  (e.g., stomach, gall bladder, liver, etc)
- ☐ Orthopedic
  (e.g., joint replacement, bones, spinal fusion, etc)
- ☐ Neurosurgery
  (e.g., brain surgery, spinal fusion, etc)
- ☐ Vision
  (e.g., LASIK, eye muscle correction, etc)
- ☐ Other: _____

Do you have any current or ongoing medical concerns?

Do you have problems with pain? ◯ Yes ◯ No

Severity of your pain? (low) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (high)

Location of your pain? _____

Have your medical concerns interfered with your ability to work, relate to others, or be involved in activities outside of your home? ◯ Yes ◯ No
If yes, please explain: _____

SUBSTANCE USE

Do you use alcohol? ◯ Yes ◯ No (If yes, number of drinks and frequency: _____)
Do you use recreational/illicit drugs? ◯ Yes ◯ No (If yes, drug(s) of choice and frequency: _____)
Have others viewed your use as a problem? ◯ Yes ◯ No
Have you ever tried to cut down on your alcohol or drug use or quit using? ◯ Yes ◯ No
If yes, please explain:

Has alcohol/drug use interfered with family, work, or interpersonal life? ◯ Yes ◯ No
If yes, please explain:

Have you had any prior substance abuse treatment? ◯ Yes ◯ No

When?	Where?
_____	_____
_____	_____
_____	_____

LEGAL HISTORY

Are you involved with the legal system, Friend of the Court or Child Protective Services? ◯ Yes ◯ No
If yes, explain:

Do you currently have a probation or parole officer? ◯ Yes ◯ No
If yes, name:

Have you been involved with the legal system in the past? ◯ Yes ◯ No
If yes, explain:

Client Signature: _____ **Date** _____