POSITIVE CHOICES COUNSELING SERVICES

Adult Intake

TO HELP WITH YOUR TREATMENT PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date:_____ Birth Date:_____ SS#:_____

Name:_____ LA Medicaid #:_____

Medicaid Address:_____ City/State/Zip:_____

Physical Address: _____ City/State/Zip: _____

Home Phone:_____ Cell Phone:_____

Employer/Job Title:_____ Pharmacy: _____

Work Phone:_____ Other Insurance: _____

ANY CHURCH MEMBERSHIP:_____

Briefly describe your **spiritual life**:_____

Last year of school completed:_____ or **GED** College 1 2 3 4 Degree:_____

Marital Status: (Please circle) Single Married Separated Divorced Remarried Widowed

Total number of marriages for you_____ for your spouse/partner_____

Spouse's name:_____ Age:_____ # of yrs. Married:_____

Is it okay to call your home & leave a message: (please circle) Yes No

Is it okay to call your work & leave a message: (please circle) Yes No

Is it okay to call your cell & leave a message: (please circle) Yes No

Person to contact in case of an emergency (name/phone):_____

_____

Who referred you to us?_____

Briefly describe your reason for seeking counseling:_____

_____

_____

Do you have children? (Please circle) Yes No

Please list everyone living in your home (First name/Age/Sex/Relationship to you)
(biological/step/adopted/foster)

Your Parents': **FATHER** Age:_____ or Deceased; **MOTHER** Age: or Deceased

Number of **Brothers**:_____ Number of **Sisters**:_____

Has anyone in your family ever had counseling before? If so, for what?_____

Any history of drug/alcohol for (circle one if applicable) self, father, mother siblings? Yes No

If yes, please describe:_____

Any history of physical or sexual abuse to you or your siblings? Yes No

If yes, please describe:_____

Do you use alcohol or non-prescription drugs? Yes No

If yes, describe frequency and type:_____

Have you ever experienced any sexual difficulties: Yes No

If yes, please describe:_____

Have you ever had counseling before? Yes No

If yes, describe and list counselor (or agency), rough number of session, and any psychiatric hospitalizations:_____

Describe any major changes that have occurred to you or your famiy in the last few years? (moves, changes in number of family members, marital statues, situation, or income)

_____

_____

List any major health problems for which you have received treatment for in the last 24 months:_

_____

_____

Primary Care Physician:_____

Phone:_____

Are you taking any prescription drugs at this time? Yes No

If yes, what type, for what purpose, and who prescribed?_____

_____

_____

Please circle any of the following problems that pertain to you:

Nervousness	Depression	Fear
Shyness	Sexual Problems	Suicidal Thoughts
Seperation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feeling	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

Name:_____