LSC
LIVING SUCCESS CENTER
A Pathway to Mental Health & Wellness

Adult Intake Form

General Information

Name: ____ Date:_________
First Middle Last

Address: ____

Phone: ____
Home Cell Work

What is the best number to reach you at: Home / Cell / Work Email Address: ___________________________________

May we leave a text: Yes / No Gender: Female ____ Male ____ Other ___________________________

Age: _____________ Date of Birth: __________________ Ethnicity______________________________
MM/DD/YYYY Please list as many as you identify with

Social Security No: ________________________________ Employed: Yes / No

Occupation: _______________________________________ How Long? _________________________

Monthly Household Income: ___________________________ # in Household: ______________________

Currently in School? Yes / No If so: Full Time / Part Time Highest Grade Lever Completed: ___________

Marital and Family Information

Relationship Status: Single / In a Relationship / Engaged / Married / Separated / Divorced / Widowed

# of Previous Marriages for You:_____________ # of Previous Marriages for Spouse/Significant Other:________

# of Years Married:___________ # of Years in Current Relationship:_______________

# of Years Divorced: _______ Length of Separation: _______ # of Pregnancies: _______ # of Children: ______

Please list children by age: (include step, adopted, foster children)						
Name	Age	Sex	Education/Grade	Living with whom?	Relationship to You	Special concerns

Please list any other person(s) living in your home:				
Name	Age	Sex	Relationship	Special concerns

I was child number____________in a family of__________children.

I was adopted: Yes / No
Circle One

Family History - Indicate if any of the following is true for yourself or a family member						
	Self	Mother	Father	Sibling	Grandparent	Other significant family member - Please Specify:
Depression						
Suicide						
Suicide Attempt						
Alcohol Problem						
Drug Problem						
Mental/Emotional problem						
Abuse						
Other Major Trauma (i.e. rape, combat, etc.) - Please Specify:						

Medical Information

Name, Address & Phone # of Physician:____

____

Date of Last Exam:_________________ General Health Assessment: _________________

List all medications you are now taking (including prescription & non-prescription such as vitamins, etc.):

Name of Medication:	Dosage & How many times a day:	Prescribed by:

Please circle any and all of the following medical you have or have had in the past:

Heart Trouble	Frequent/Severe Headaches	Head Injury/Knocked Unconscious
Diabetes	High blood Pressure	Epilepsy/Seizures/Convulsions
Stroke	Shortness of Breath	Fainting/Dizziness
Kidney Trouble	Bedwetting/Soiling	Stomach Problems
Back Problems	Unusual Bleeding	Asthma/Hay Fever
Arthritis	Sleep Difficulty	Neurological Disease

Any other Serious Illness, Injury, or Surgery:

Type of illness/injury/surgery	Name, Address, &Phone# of Treating Physician	Date of Illness/Injury/Surgery

Client Initial _________

Prior Psychotherapy - Have you consulted a therapist of any type in the past (Circle one)? YES NO

Name of Counselor/Therapist	Address & Phone #	Date(s) of Service

Have you ever been hospitalized for psychiatric reasons in the past? (Circle one) YES NO

Name of Hospital	Address & Phone #	Date(s) of Hospitalization

Please provide names of people we can contact in case of an emergency

Name of Person	Phone#	Relationship to You

Problem Areas/Areas of Concern

Please check any of the following problem areas that led you to seek counseling along with level of concern:
For example, if you came in for issues related to marital problems you would check that category and put the number in level of concern. The levels are as follows:

1= Area of concern but generally handing the situation
2= Moderate concern for me and I'm ready to seek help
3= Enough of a problem as it is beginning to affect my functioning in at least 1 area of my life God, home, relationship, school, legal, etc.)
4= Problem is affecting multiple (2 or more) areas of my life and/or my day to day functioning
5= Severe problem, affecting all aspects of my life and limits my ability to function day to day

Specific Problem Area	Check if Problem	Level of Concern	Specific Problem Area	Check if Problem	Level of Concern
Abortion			Issues surrounding sexual orientation		
Adoption			Job Issues/Satisfaction		
Alcohol Use			Legal Issues		
Anger/Frustration/Temper			Loneliness		
Anxiety/Excessive Worry			Loss of Appetite		
Apathy			Loss of Energy		
Birth of a Child			Loss of Memory		
Bitterness/Resentment			Loss of Trust		
Burnout/Stress			Marital or Relationship Problems		
Change of Lifestyle			Medication/Drug Issues		
Child Abuse			Mid-Life		
Children/Discipline			Mood Swings		
Children/School			Mother Issues		
Children/Rebellion			Male Issues		
Communication			Panic Attacks	- - -	
Confusion			Parenting		
Concentration/Focusing			Pre-Marital Issues		
Crisis/Traumatic Event			Physical Abuse		
Death or Loss of Loved One			Religion/Faith Issues		
Depression			Separation		
Divorce			Sexual Abuse		
Eating Disorder			Sexual Addiction		
Envy/Jealousy			Sexual Issues/Performance		
Family Issues			Sexual Fetishes		
Fear/Phobias			Singleness		
Finances/Debt			Single Parent		
Forgiveness			Spousal Abuse		
Friendships Problems			Substance Abuse		
Guilt/Shame			Suicidal thoughts		
Health/Medical Issues			Self-esteem		
Honesty			Rejection		
Housing/Living Arrangements			Unemployment		
Incest			Other: (Please List Below)		
Infidelity/Affairs					
In-Laws					
Insomnia					

Client Initial __________

Please write a brief statement about the problem(s) or areas of concern that brought you in to counseling:

____

____

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____

____

What do you hope to gain from coming to counseling?

____

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Have things improved in any way since you made your initial appointment? (Circle one) YES NO

If so, how? Please write a brief statement:

____

____

____

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Appointment Cancellations Policy:

If an appointment is cancelled or missed without 24 hours prior notice, a regular charge will be made and carried on in your balance. Please note that Monday appointments must be cancelled by noon on Friday.

Whom may we thank for referring you to us? ____

This form was completed by: ____________________________ on _________________

Name Date

Client Initial _________