FIGURE&GROUND
COUNSELING
LLC

Adult Intake and Self-Report Form

Name _____ **Date of Birth** _____

Address _____

Phone Number _____ **home/cell** _____ **work**

Email address _____

Is it okay to leave reminders on the following: phone _____

text _____

email _____

Chief Concern

Please describe the main difficulty that has brought you to see me:_____

_____

_____

Your medical care

(From whom or where do you get your medical care?)

Clinic name _____

Phone _____

Doctor's name _____

Address _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? **Yes** **No**

Your current employer

Employer _____

Work phone _____

Address _____

Occupation _____

Length of time with this employer _____

Gender, Sexual Orientation

How do you best describe your gender? _____ male, _____female, _____ transgender, _____ non-binary or fluid.

How do you describe your sexual orientation? ____ heterosexual, ____ homosexual, ____bisexual, ____pansexual, ____asexual, _____ other

How do you get along with your spouse or partner?

How would you describe your levels of satisfaction with sexual interactions? ____ very good, ____ average, _____ some difficulty, or _____ much difficulty?

Present relationships

How do you get along with your children? What is your biggest complaint?

How well do you get along with your family? Mother? Father? Siblings?

How well do you get along with friends?

Who supports you the most?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? **Yes** **No**

Please indicate which type of treatment (circle one): **Inpatient** **Outpatient** **Both**

If yes, please indicate:

When _____

From Whom _____

For What _____

Results _____

Medications

Have you ever taken medications for psychiatric or emotional problems? **Yes** **No**

If yes, please indicate:

When _____

From Whom _____

For What _____

Results _____

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Family

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Job/school performance

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Friendships

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Financial situation

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Physical health

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Anxiety level / nerves

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Mood

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Eating habits

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Sleeping habits

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Sexual functioning

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Satisfaction of Sexual relationships

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Alcohol / drug use

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Ability to concentrate

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Ability to control anger

1 - No effect **2** – Little effect **3** – Some effect **4** – Much effect
5 – Significant effect **Not Applicable**

Substance Use

Do you currently consume alcohol? **Yes** **No**

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? **Yes** **No**

Have family members or friends expressed concern about your drinking? **Yes** **No**

Do you currently use non-prescribed drugs or street drugs? **Yes** **No**

Do you have a history of problematic use of prescription or non-prescription drugs? **Yes** **No**

Do you have a family history of alcohol or drug problems? **Yes** **No**

If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.