Open Heart Counseling ATX
Hope & Healing After Trauma

ADULT INTAKE FORM

Demographic Information:

Name: _____ Nickname: _____
Address: _____ Phone: (____)_____
D.O.B.: ____/____/_____ Age: _____ Relationship Status:_____ Partners Name: _____
Racial Identity: _____ Preferred Pronouns: _____

Employment & Education Information:

Current Employment Status: _____ Employer: _____
Position Title: _____
Education Experience: _____

Current Concerns:

What concerns bring you into counseling?_____
_____
_____

When did these concerns begin? _____
_____
_____

Please describe significant events occurring at that time, or since then, which may relate to the development of this concern: _____
_____
_____

Have you had any intrusive thoughts, excessive worry, or feel panicky? Describe: _____
_____
_____

Do you have any flashbacks, triggers, or find yourself avoiding certain people/places? _____
_____
_____

Are you experiencing any sadness, loss of interest, or inability to experience joy? _____
_____
_____

Are you experiencing significant mood changes that last multiple days? Explain: _____
_____
_____

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Any sleeping difficulties:_____
_____
_____

Do you have any current or past suicidal or homicidal thoughts/attempts? Explain: _____
_____
_____

Other concerns or difficulties you have: _____
_____
_____

Please check any *behaviors* that apply to you:

□Aggression	□Drug usage	□Sleeping issues
□Angry outbursts	□Disordered eating	□Self-harm/injury
□Avoidance	□Grieving	□Suicidal attempts
□Body focused repetitive behaviors	□Impulsive reactions	□Take risks
□Compulsions	□Inappropriate boundaries	□Vomiting
□Concentration difficulties	□Intrusive thoughts/obsessions	□Withdrawal
□Cry too much	□Lack of motivation	□Work too much
□Drink too much	□Loss of control	□Other: _____

Please check any *feelings* that stand out to you below:

□Alone	□Fearful	□Rage
□Anger	□Guilty	□Regretful
□Annoyed	□Happy	□Restless
□Anxious	□Helpless	□Sad
□Bored	□Hopeful	□Shameful
□Conflicted	□Hopeless	□Tense
□Depressed	□Lonely	□Unhappy
□Energetic	□Optimistic	□Unloved
□Envious	□Panicky	□Upset
□Excited	□Powerless	□Other: _____

Please check any *physical symptoms* that apply to you:

□Blackouts	□Nightmares	□Tension
□Don't like being touched	□Panic/anxiety attacks	□Tics
□Fainting spells	□Rapid heartbeat	□Tingling skin/limbs
□Fatigue	□Seeing things	□Tremors
□Headaches	□Sexual disturbances/pain	□Unable to relax
□Hearing things	□Stomach trouble	□Other: _____

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Grief and Trauma History:

Have you had any significant losses? (death, pregnancy, job loss, pet loss, divorce etc.) _____

Have you ever been abused or assaulted? (sexual, physical, verbal, family violence etc.) _____

Have you experienced trauma? (racial, medical, accident, violence, natural disaster, etc.) _____

Has racism, oppression or discrimination been a problem in your life? Explain: _____

Social History:

Are you having difficulties or stress at your current job? _____

Are you having difficulties with your current significant other? _____

Are you having difficulties in any of your relationships with other people? _____

Who are your support systems? _____

Is religion or spirituality important in your life? Describe:_____

Has race, ethnicity or culture played an important role in your life? Describe: _____

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Pregnancy & Postpartum/Reproductive History:

Please describe your pregnancy journey (planned/unexpected, fertility struggles, loss etc.):_____

_____

_____

Please describe your (or your spouses) pregnancy. Were there any complications? _____

_____

_____

Please describe your (or your spouses) childbirth. Were there any complications? _____

_____

_____

Did your baby(ies) experience any complications or go to NICU/PICU? For how long? _____

_____

_____

Please describe your postpartum journey (PPD, PPA, PTSD, OCD) etc:_____

_____

_____

Previous Mental Health History:

Have you attended counseling before? □ Yes □ No Dates: _____

Reasons for previous counseling: _____

Do you have a previous mental health diagnosis? _____

Have you ever been admitted to a psychiatric hospital? □ Yes □ No Dates: _____

Length of stay: _____ Reasons: _____

Medical History:

Have you ever been hospitalized for an illness? _____

_____

Have you or are you currently seeing a psychiatrist? Who and for what purpose?_____

_____

Current Medications:

Name: _____ Purpose: _____ Dosage: _____ Frequency: _____

Name: _____ Purpose: _____ Dosage: _____ Frequency: _____

Name: _____ Purpose: _____ Dosage: _____ Frequency: _____

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Family History:

Describe your family structure growing up: _____

_____

_____

_____

_____

Describe relationships among your family members growing up: _____

_____

_____

_____

_____

How would you describe your upbringing? _____

_____

_____

_____

_____

How would you describe your teenage years? _____

_____

_____

_____

_____

Has anyone in the your family experienced the following:

□Mental health illness Type: _____ Relationship to you: _____

□Abuse or trauma Type: _____ Relationship to you: _____

□Drug/alcohol abuse Type: _____ Relationship to you: _____

□Suicidal behaviors Type: _____ Relationship to you: _____

□Incarceration Length of time in jail: _____ Relationship to you: _____

Is there anything else about you that would be helpful for me to know? _____

_____

_____

_____

Goals for counseling:_____

_____

_____

_____