# Vickie Purdy, LPC

**Professional Counseling Services**

## Adult Intake Form

**The information requested on this form will be kept confidential. Please fill out the form as completely as possible.**

Were you referred for counseling? Y / N By whom? _____

For what reason? _____

How did you choose Vickie Purdy's Counseling Services over other options? _____

What would you like to see happen as a result of counseling? _____

Did something happen to prompt you to seek help now, versus when the problem first began? _____

_____

Are you seeking disability due to your current mental/emotional health? Y / N
Are you seeking counseling due to a court order or criminal charges? Y / N

### Client Information

Last Name: _____ First Name: _____ Middle Initial: _____

Birth Date: _____/_____/_____ Social Security Number: _____/_____/_____

Street Address: _____ Apt. # _____

City: _____ State: ____ Zip: _____ Home Phone: _____

Cell Phone: (_____) _____ Email: _____

May our office: ____Call? _____ Leave a message? _____ Text? Prefer: _____Cell? _____ Home?

**Gender**
___ Male
___ Female
___ Non-binary/3rd gender
___ Prefer to self-describe
_____
____ Prefer not to say

**Sexual Orientation**
____ Straight/Heterosexual
____ Gay/Lesbian/ or Queer
____ Bisexual
____ Prefer to self-describe
_____
____ Prefer not to say

**Do you identify as transgender?**
____ Yes
____ No
____ Prefer not to say

**Relationship status: (Circle one)** Single Significant other Cohabitating Engaged

Married / How long? _____ Separated Divorced Widowed / How long? _____

**Racial/Ethnic Identity:** Black/African American Asian American Hispanic/Latino Native American

Pacific Islander White/Caucasian Other: _____

**Emergency Contact:** Name: _____ Phone: _____

Relationship to the client: _____

**Military Service:** (circle) Active Duty National Guard/Reserves Prior Service Retired Dependent

Medically Separated Service Connected Disability Combat Veteran Branch: _____ Dates of Service: _____

**Education:** (Circle highest level of education completed) GED High School Graduate Grade: ___ Some College

Associate's Degree Bachelor's Degree Master's Degree Post-Graduate Degree Professional Certification

Current Student at: _____ Studying: _____

Other: _____

**Employment:** ____ Full-Time ____ Part-Time _____ Self-Employed _____ Homemaker

_____ Student _____ Retired _____ Disabled ____ Unemployed

Employer: _____

What type of work do you do? _____

**Family:**

Parents: Mother Living (age) _____ Deceased (date & age at death) _____

Father Living (age) _____ Deceased (date & age at death) _____

Siblings: How many? _____ I am: ___ Oldest ___Middle ____ Youngest ___ Only Child

Children: (Names and ages) _____

Step-Children: (Names and ages) _____

Who lives at home with you? _____

Have any of your children died? Y / N If yes, please provide details. _____

_____

What do you consider the most significant events in your life? _____

_____

Have you or anyone in your family experienced domestic violence or abuse? Y / N

Are you currently experiencing domestic violence or abuse? Y / N

**Religion/Denominational Preference:** _____ Congregation (if any): _____

**Medical History of Client**

Primary Physician _____ Date of last medical examination _____

List any physical illnesses or symptoms you have at this time: _____

Major surgeries or illnesses in the last five years: _____

Current medications (include dosages and physician prescribing): _____

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Have you experienced any of the following problems/conditions the last two months (Circle all that apply):

| | | |
|---|---|---|
| Thoughts of suicide | Anxiety | Rage |
| Thoughts of death | Excessive worry | Anger |
| Plans to harm self | Panic attacks | Irritability |
| Thoughts of harming others | Chronic fear | Relationship w/ lover |
| Plans to harm others | Irrational fears | Relationship w/ parents |
| Self-injury | Problems due to abuse/trauma | Relationship w/ children |
| Loss of meaning in life | Stress | Sexual problems |
| Loss of hope | Obsessions | Sexual orientation |
| Depression | Compulsions | Gender identity issues |
| Decreased pleasure | Phobias | Conflicts at work |
| Lack of activities | Feeling like I'm losing control | Problems in school |
| Isolating/withdrawal | Restlessness | Loss of faith in God |
| Decreased energy/fatigue | Muscle tension | Religious doubts |
| Change in appetite | Problems with sleep | Substance use problems |
| Significant weight change | Problems with concentration | Hallucinations |
| Feelings of worthlessness | Problems with memory | Delusions |
| Grief | Avoiding certain spaces | Easily distracted |
| Loneliness | Behavioral problems | Other/ Explain below: |
| Feelings of guilt/shame | ADHD/ADD | |

**What else are you experiencing at this time? _____**

_____

**Mental Health**
Have you experienced mental health problems before? Y / N If yes, please explain: _____

Do you have a family history of mental health problems? Y / N _____

Have you ever received outpatient treatment (seen a counselor/therapist/psychologist/psychiatrist) for mental health issues? Y/ N If yes, please share pertinent details (who, what, when, where, and why). _____

_____

Have you ever been hospitalized, or received inpatient treatment for mental health issues? Y / N

If yes, when and where? _____

**Self-Harm**
Have you ever attempted suicide? Y / N If yes, number of attempts and when they were made: _____

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Have you ever lost someone you care about to suicide? Y / N If yes, who and when? _____

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Have you ever engaged in cutting or self-mutilation? Y / N When was the last time? _____

**Substance Use History**
Do you drink alcohol? Y / N On average, how many drinks do you have? _____ per _____
(amount and type ) (day/week/month)
Do you use drugs (illegal drugs, recreational drugs, drugs not prescribed to you, or used in excess of how they are prescribed)? Y / N If yes, which ones? _____
How often? _____ per _____. IV drug use? Y / N
(quantity and type of drug used) (day/week/month)

Have you ever received outpatient treatment (counseling, therapy, psychiatrist, or medication) for a drug or alcohol problem? Y / N If yes, when and where? _____

Completed successfully? Y / N

Have you ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem? Y / N

If yes, when and where? _____

Completed successfully? Y / N

What other information is important for you to share with your therapist? _____
_____

**Acknowledgement**
The information written on this form is accurate, to the best of my knowledge.

_____ _____
Signature of Client Date