Wellbeing Counseling

Wellbeing Counseling/2024 82nd St., Suite 101
Lubbock, TX 79423/806-853-6540

Adult Intake Form

CLIENT INFORMATION

Today's Date ___/___/___ Referred By _____

Name _____ Age _____

Preferred Name _____ DOB ___/___/___

Occupation ☐ Student ☐ Employed, full-time ☐ Employed, part–time ☐ Volunteer ☐ Unemployed

Relationship Status ☐ Single ☐ Dating ☐ Married ☐ Divorced ☐ Separated ☐ Civil Union

Address _____

_____

Preferred Phone ( ) _____-_____

Other Phone ( )_____-_____

Preferred Email _____

Emergency Contact _____

What is your preferred form of communication with us?

☐ Phone call ☐Text ☐ Email

May we leave a voicemail at your preferred number? Yes No

SYMPTOMS CHECKLIST

Difficulty sleeping	Anxious/Nervous	Quick to lose temper
Crying a lot	Feeling depressed	Feeling hopeless
Trouble w/ focus	Trouble maintaining	Frequent outbursts
Loss of appetite	Increase in appetite	Withholding food
Substance misuse	Unable to maintain	Socially withdrawing
Frequent headaches	Frequent upset GI	Sleeping a lot
Avoiding leaving your home	Harmful thoughts toward self	Harmful thoughts about others
Picking at skin/ pulling hair	Feelings of confu-sion	Difficulty remembering things

BASIC INFORMATION

What concerns have led you to seek out counseling at this time?

_____

_____

_____

_____

_____

_____

_____

PERSONAL INFORMATION

Describe your personality.

_____

_____

_____

_____

_____

What are your interests and strengths?

_____

_____

_____

_____

_____

What are your stresses and/or struggles?

_____

_____

_____

_____

_____

Have you been in counseling/therapy before? Yes No

Counselor's name and dates seen:

_____

_____

Outcome & Diagnosis (if any):

_____

_____

_____

Have you been seen by a psychiatrist? Yes No

Psychiatrist's name and dates seen:

_____

_____

_____

_____

Have you struggled with substance misuse/abuse (tobacco/ alcohol/prescription medications/street drugs) or displayed addictive behaviors not related to substances. Yes No Prefer not to answer

If so, please describe:

_____

_____

_____

Do you struggle with thoughts to harm yourself or experience suicidal thoughts? Yes No

If so, please describe:

_____

_____

_____

_____

Have you had any legal issues (police or legal system) that you feel the counselor needs to be aware of? Yes No

If so, please describe:

_____

_____

_____

Have you experienced any traumas? Yes No

Please describe any traumatic experiences below., if comfortable doing so:

_____

_____

_____

_____

Are you currently taking any prescribed psychotropic medications (anti-depressant, anti-anxiety, etc.)?

Please list:

_____

_____

_____

_____

Any religious/spiritual needs the counselor needs to be aware of? Yes No

If so, please describe:

_____

_____

_____

Any ethnic or cultural issues the counselor needs to be aware of? Yes No

If so, please describe:

_____

_____

_____

Any family issues the counselor needs to be aware of?

If so, please describe:

_____

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_____

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_____

OTHER INFORMATION

Are there any other concerns or issues you feel the counselor should be aware of? If so, please describe:

_____

_____

_____

_____

What is your desired outcome with counseling?

_____

_____

_____

_____

_____

_____

Please let us know how you found us?

☐ Referral ☐ Internet ☐ Other

_____

_____

_____

Thank you for taking the time to fill out this intake. It is of the utmost importance to us that we learn about you and the concerns that lead you to our practice!