BreakThru
Counseling and Consulting, P.C.

Adult Intake Information

The following information will become a part of your confidential file. This will help us to focus more clearly on the areas of concern that you may desire to work on in counseling. Please answer each question as completely and carefully as you can. If you're in couple's counseling, be aware this information will be shared with your spouse/partner in our work together as a team.

Please Print in Black Ink:

Name ___________________________________ Date of Birth __________ Age _____
Male __ Female __ Race_____________ Ethnicity/Culture_____________________________
Presently living with: ___Parents ___Spouse ___Alone Other ____________
Occupation ____________________________ Hours Worked Weekly _____________________
Employed By __________________________ Work Phone ______________________________
Home Phone ____________________ Cell Phone_____________________
OK to leave a voicemail at Home? ___ Work? ___ Cell? ____ OK to Text Cell #? _____
Email: __________________________ OK to contact you by email? Yes__ No___

We need to alert you if you choose to communicate with us by electronic transmission (faxes, cell phone, and/or emails), that, in this day and age of hackers, there is no 100% guarantee of confidentiality for any of us via electronic transmission. Thus, privacy of electronic transmissions cannot be assured. If you indicate on this form that you are "OK" for BreakThru to contact you via cell phone, text, and/or email your signature below serves as your agreement to assume the risks to client confidentiality involved with any electronic communication. However, we'll do our utmost to preserve your confidentiality on our end.

Current Marital Status: __ Single __ Married __ Remarried __ Separated
__ Divorced __Widowed
U.S. Citizen? Yes No If No, Explain Status____
Emergency Contact: ___________________________ Phone:________________
Relationship to Client :___________________

Educational Background

Circle last year of school completed: Grade School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 5+
Grad School: 1 2 3 4 5+ In Any Special Programming in School?______
____

Medical/Counseling Background

Describe any current physical problems or handicaps you have that require medication or medical treatment:
____
____
List medications and dosages you are taking for any physical problem.
____
Allergies?___ What Type?____________________
Have you used drugs for **other than** prescribed medical purposes? Yes No
If so, what drugs? __________________________ When was the last time you used? _________
Have you been in counseling/therapy/mental health care before? Yes No
If yes, when? ________________________ For what reason? ______________________________
Psychiatric facility name(s) and/or Therapist Name(s): ___________________________________
Have any of your family members ever received counseling? Yes No
If so, what issues/problems were addressed? ______________________________________
Have you ever taken medication prescribed for emotional reasons? Yes No
When? __________________________ For what reason? _________________________________
Are you currently taking medication prescribed for emotional reasons? Yes No
If yes, what medication and dosage? ________________ For what reason(s)? ______________
Do you use alcohol? Yes No
How frequently? Few times a year __ Once a month __ Several times a month __
Once a week __ Multiple times a week __ Daily __ *Amount consumed*? _________

Do you smoke cigarettes/cigars/chew/use snuff/vape? _____ How frequently?______________
________________________________ Quantity used on average? ______________________

Marital Background

Name of Spouse __________________________ Occupation ___________________________
Is your spouse willing to participate in counseling? Yes No Uncertain
Date of this marriage ____________ Ages when married: Husband _______ Wife _______
Have you ever been separated? Yes No If Yes, when? ________________________

List all marriages, including current one, in order. Indicate your age at the time of the marriage, how long the marriage lasted, whether it was broken by death or divorce, and the basic reason for the break-up of the relationship, from your perspective.
____
____
____
____

Children/Stepchildren/Adopted children

Name	Age	Sex	By which marriage	Living at home?

Any Miscarriages? _____ Abortions? _____

Religious Background

Your religion/denomination____________________________ Active ______ Inactive ______
Spouse's religion/ denomination_________________________ Active ______ Inactive ______
What significant spiritual experiences have you experienced, or are currently experiencing?
____

Family Background

Natural Parents: Remained Married Separated Divorced Never Married
If parents separated or divorced, how old were you at the time? __________________________
Father deceased? Yes No If yes, how old were you at the time? ___________
Mother deceased? Yes No If yes, how old were you at the time? ___________
Father remarried when you were age?_______ Mother remarried when you were age ?_______
You lived with: Mother Father Adoptive Foster Other ________________________
What kind of relationship did you have with your step-parent(s), adoptive or foster parents?
____
____
____
____
Natural father's occupation ________________ Natural mother's occupation ______________
Step-father's occupation ___________________ Step-mother's occupation _________________
Adoptive father's occupation_______________ Adoptive mother's occupation______________
How many times was your father married? ______ Your mother married? _______
Rate your parents' marriage: Unhappy Happy Very Happy
Their marriage lasted __________ years.

List your brothers and sisters (including step, adopted and/or half brothers or sisters) from the oldest to youngest, giving their names and ages.

____
____
____

Check the statements that best describe the family you grew up in

_____ Warm relationship with father/mother/step-parent/adoptive/foster parent
_____ Warm relationship with brothers/sisters/step-siblings/half siblings/adopted siblings
_____ Sibling rivalry
_____ Father/mother absent physically/emotionally
_____ Moved frequently
_____ Parental job/financial instability
_____ Relatives lived nearby
_____ Close relationship with grandparents/aunts/uncles/cousins
_____ Alcohol/drug abuse/other compulsive behavior by father/mother
_____ Addictive/compulsive behavior in other family members
_____ Chronic-physical, mental or emotional illness in family members
_____ Rigid, perfectionistic standards
_____ Frequent/excessive anger and conflict
_____ Physical/emotional/sexual abuse by family members

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.
____
____
____

Have there been times when the problem got better or disappeared? Yes No
What do you think helped? ____
____
Were there times when the problem was especially bad? Yes No
What made it bad? ____
____
Are there other people who play a major role causing your problems? Yes No
…or in helping you to cope with your problems? Yes No
Explain briefly: ____
____
____

Legal Issues

Have you ever been arrested? Yes No
If so, please explain: ____
Are you involved in any current legal proceedings? Yes No
If yes, please explain: ____

Problem Areas

In the following list, place a check mark next to each item which identifies something with which you have ever had a problem. Please place an"X" by problem areas of most concern to you currently.

_____ Anger
_____ Bitterness
_____ Depression
_____ Eating Difficulties
_____ Education
_____ Fearfulness/Anxiety
_____ Financial problems
_____ Marital problems
_____ Physical problems
_____ Physically hurting yourself
_____ Problems with social relationships
_____ Problems with children
_____ Problems with parent(s)
_____ Religious/Spiritual concerns
_____ Obsessions/Compulsions
_____ Abortion
_____ Perfectionism

_____ Self esteem
_____ Sexual concerns
_____ Thoughts of hurting others
_____ Thoughts of suicide
_____ Trouble making decisions
_____ Unhappy most of the time
_____ Use of alcohol
_____ Use of alcohol or drugs by family member
_____ Use of drugs
_____ Use of tobacco
_____ Work/ Unemployment
_____ Violence toward property, others or animals
_____ Abuse issues: emotional physical sexual
_____ Legal Problems Specify _______________
_____ Delusions / Hallucinations
_____ Pornography/Sexual Addiction
_____ Other Specify ________________________

Please complete the following

1. The most important thing to me is…____
2. I worry about…____
3. I have sometimes felt guilty about…____
4. I have been criticized for…____
5. What makes me angry is…____
6. My biggest mistakes were…____
7. What makes me nervous is…____
8. I often felt that mother…____
9. Sex to me is…____
10. I often felt that father…____
11. God to me is…____
12. What hurts me most is…____
13. My biggest problem in life is…____
14. My temper…____
15. If I could change something, it would be…_____________________________________
16. I secretly…____
17. My child(ren)…____

My signature below serves as my acknowledgement that the above information I've given is accurate and that I accept the risks to client confidentiality by choosing to engage in electronic communication with BreakThru Counseling and Consulting, P.C..

___________________________ ___________
Client Date

___________________________ ___________
Witness Date