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 couples counseling at BCC, be aware this information will be shared with your spouse/partner in our work together as a team.

Please Print in Ink:

Name _____ Date of Birth _____ Age _____

Male _____ Female _____ Race: _____ Ethnicity/Culture: _____

Presently living with: ☐ Parents ☐ Spouse ☐ Alone ☐ Other _____

Occupation _____ Hours Worked Weekly _____

Employer _____ Work Phone _____

Home Phone _____ Cell Phone _____

OK to leave a voicemail at Home? ☐ Yes ☐ No Work: ☐ Yes ☐ No Cell: ☐ Yes ☐ No

Email: _____ OK to contact you by email? ☐ Yes ☐ No

We need to alert you if you choose below to communicate with us by electronic transmission (texts, cell phone, faxes and/or emails) you assume the risk this may pose to client confidentiality. 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. 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

Place an "X" on last year of school completed:

High School: 9 10 11 12 College: 1 2 3 4 5+ Grad School: 1 2 3 4 5+

Any special Programming in School? _____

Medical/Counseling Background

Describe any physical problems or handicaps you have that require medication or medical treatment:

_____

Are you currently receiving medical treatment? ☐ Yes ☐ No

If yes, for what purpose? _____

List medications and dosages you are taking for any physical problem.

_____

Allergies? _____ What Type? _____

Have you used drugs for **other** than 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
Average amount consumed? _____ Last Used: _____
Do you smoke: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Use Snuff ☐ Vape
How Often? _____
Quantity used on average? _____ Last Used: _____

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? ☐ Yes ☐ No Abortions? ☐ Yes ☐ No

Religious Background

Your denominational preference _____ Active _____ Inactive _____
Spouse's denominational preference _____ 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/relationship 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.

_____

_____

Place an "X" by the statements that best describe your family history

_____ 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 **one "X"** next to each item which identifies something with which you have ever had a problem. Please place **two "X"s** by problem areas of most concern to you currently.*

___ Anger	___ Self esteem
___ Bitterness	___ Sexual concerns
___ Depression	___ Thoughts of hurting others
___ Eating Difficulties	___ Thoughts of suicide
___ Education	___ Trouble making decisions
___ Fearfulness/Anxiety	___ Unhappy most of the time
___ Financial problems	___ Use of alcohol
___ Marital problems	___ Use of alcohol or drugs by family member
___ Physical problems	___ Use of drugs
___ Physically hurting yourself	___ Use of tobacco
___ Problems with social relationships	___ Work/Unemployment
___ Problems with children	___ Violence toward property, others or animals
___ Problems with parent(s)	___ Abuse issues: emotional physical sexual
___ Religious/Spiritual concerns	___ Legal Problems Specify: _____
___ Obsessions/Compulsions	___ Delusions / Hallucinations
___ Abortion	___ Pornography/Sexual Addiction
___ Perfectionism	___ 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 information I've given is accurate and that I accept the risks to client confidentially by choosing to engage in electronic communication with Breakthru Counseling & Consulting, P.C. (BCC).

I voluntarily choose and ask that my typed name on the signature line(s) of this document legally represent my electronic signature.

_____ _____

Client Name (Please Print) **Date**

_____ _____

Client Signature **Client DOB**