

**Blue Water Counseling**  
**Intake Assessment Information – Adult Form**  
*(Please print all information)*

**I. ADULT CLIENT**

TODAY'S DATE: \_\_\_\_\_

A. NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

B. What are the concerns for which you are seeking assistance? \_\_\_\_\_

**II. FAMILY INFORMATION**

A. YOUR MARITAL STATUS:

Single     Married     Divorced     Separated     Cohabiting     Widowed

B. RACE/CULTURAL INFORMATION

1. Race: \_\_\_\_\_

2. Cultural Considerations: \_\_\_\_\_

C. FAMILY HISTORY OF MENTAL HEALTH OR SUBSTANCE ABUSE PROBLEMS:

NO     YES    Explain: \_\_\_\_\_

D. YOUR PARENTS ARE:     Married     Divorced     Separated     Never Married

Your parents are:     Birth Parents     Step Parents     Adoptive Parents

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ If Deceased, Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ If Deceased, Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Grade Level: \_\_\_\_\_

E. YOUR ANNUAL FAMILY INCOME:     Under \$30,000     \$31,000 – \$60,000     \$61,000 – \$90,000

\$91,000 – \$120,000     \$121,000 – \$150,000     Over \$151,000

F. LANGUAGE SPOKEN: \_\_\_\_\_

G. CURRENT FAMILY SIZE: \_\_\_\_\_

H. YOUR BROTHERS AND SISTERS:

NAME	AGE	OCCUPATION	EDUCATION	IF DECEASED, DATE & CAUSE	BIOLOGICAL, ADOPTED OR STEP

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**I. YOUR CHILDREN**

NAME	AGE	SEX	OCCUPATION OR GRADE	LIVING WITH CLIENT?	BIOLOGICAL, ADOPTED OR STEP
				[ ] Yes [ ] No Where?	
				[ ] Yes [ ] No Where?	
				[ ] Yes [ ] No Where?	

**J. OTHER HOUSEHOLD MEMBERS**

NAME	AGE	SEX	OCCUPATION OR GRADE	RELATIONSHIP TO CLIENT

**K. RELATIONSHIPS**

1. Who do you live with currently? \_\_\_\_\_
2. Who did you grow up with? \_\_\_\_\_
3. Describe your relationship with:
  - Parents: \_\_\_\_\_
  - Siblings: \_\_\_\_\_
  - Extended Family Members: \_\_\_\_\_
  - Husband/Wife/Significant Other: \_\_\_\_\_
  - Your Children: \_\_\_\_\_
4. List any family members you wish to have involved in treatment and why : \_\_\_\_\_  
 \_\_\_\_\_

**III. PHYSICAL DESCRIPTION**

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A. Height \_\_\_\_\_ Weight \_\_\_\_\_ Recent Gains or Losses \_\_\_\_\_

B. Other distinguishing features: \_\_\_\_\_

C. Do you have any physical impairments or disabilities? If so, explain: \_\_\_\_\_

D. Are physical characteristics or body image a concern? Explain: \_\_\_\_\_

**IV. EDUCATION**

A.  Graduated from High School (year): \_\_\_\_\_ or  GED?(year) \_\_\_\_\_

B.  Did not complete school If yes, last school attended: \_\_\_\_\_ Grade completed: \_\_\_\_\_

C.  Currently enrolled If yes, last grade completed: \_\_\_\_\_ Current grade \_\_\_\_\_

D.  Post high school education. Explain: \_\_\_\_\_

E.  Years in special education: \_\_\_\_\_ Special Education certification: \_\_\_\_\_

F. Is or was school performance a concern for you? Explain: \_\_\_\_\_

**V. EMPLOYMENT**

A. Are you currently employed?  Yes  No If yes,  Full time  Part time  Seasonal

B. Name of employer? \_\_\_\_\_

C. Position: \_\_\_\_\_

D. List the types of jobs you have held over the past five years: \_\_\_\_\_

E. Are you satisfied with your employment/career: \_\_\_\_\_

**VI. SPIRITUAL INFORMATION**

A. Is spirituality an area of support or strength for you?  Yes  No

RELIGION:  Catholic  Jewish  Islamic  Protestant  Other: \_\_\_\_\_

B. Is this an area of concern?  No  Yes Explain: \_\_\_\_\_

**VII. SEXUAL FUNCTIONING**

Is this an area of concern?  No  Yes Explain: \_\_\_\_\_

**VIII. COMMUNITY SERVICES RECEIVED CURRENTLY OR PREVIOUSLY**

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**A. MENTAL HEALTH COUNSELING/SUBSTANCE ABUSE TREATMENT**

1. Previous Counseling: Where: \_\_\_\_\_ When: \_\_\_\_\_  
Where: \_\_\_\_\_ When: \_\_\_\_\_  
Where: \_\_\_\_\_ When: \_\_\_\_\_
2. Was counseling helpful to you in the past? \_\_\_\_\_

**B. SUPPORT GROUPS**

1. List any support groups you attended in the past or presently: \_\_\_\_\_  
\_\_\_\_\_
2. Was support group attendance helpful? \_\_\_\_\_

**IX. SUBSTANCE USE**

- A. Do you use illegal or unprescribed drugs including alcohol? [ ] No [ ] Yes If yes, explain which drugs, amount and frequency: \_\_\_\_\_  
\_\_\_\_\_
- B. Do you misuse prescription drugs? [ ] No [ ] Yes If yes, explain which drugs and how they are misused: \_\_\_\_\_
- C. Do you drink alcohol? [ ] No [ ] Yes If yes, how often per week? \_\_\_\_\_  
Amount: \_\_\_\_\_
- D. Is drug or alcohol use an area of concern: [ ] No [ ] Yes If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
- E. Has anyone ever expressed concern with your use of alcohol or other drugs? \_\_\_\_\_  
\_\_\_\_\_
- F. Have you ever been to an Alcoholics Anonymous or Narcotics Anonymous meeting? [ ] No [ ] Yes
- G. Have you ever had a legal charge related to alcohol or other drug use? [ ] No [ ] Yes If yes, explain: \_\_\_\_\_  
\_\_\_\_\_
- H. Do you smoke cigarettes now? In the past? [ ] No [ ] Yes If yes, explain time period, amount and frequency: \_\_\_\_\_

**X. SOCIAL LIFE**

- A. Describe your family's strengths: \_\_\_\_\_  
\_\_\_\_\_
- B. Describe your support system (ie. family, friends): \_\_\_\_\_  
\_\_\_\_\_

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C. Describe your recreational interests: \_\_\_\_\_  
 \_\_\_\_\_

D. Describe any relationship problems with friends/coworkers: \_\_\_\_\_  
 \_\_\_\_\_

**XI. HEALTH HISTORY**

A. PRIMARY PHYSICIAN: \_\_\_\_\_

1. Primary Physician's Address: \_\_\_\_\_

2. Primary Physician's Phone: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

B. MEDICATIONS: List all current prescriptions, regularly taken - over the counter meds and supplements:  
 \_\_\_\_\_  
 \_\_\_\_\_

C. Concerns about medications including drug allergies? [ ] No [ ] Yes Explain: \_\_\_\_\_  
 \_\_\_\_\_

D. HEALTH PROBLEMS ( Check applicable columns):

<i>Problem</i>	<i>Never</i>	<i>Past</i>	<i>Present</i>	<i>Family History</i>
<i>Allergies</i>				
<i>Anorexia</i>				
<i>Asthma</i>				
<i>Broken Bones</i>				
<i>Communicable Diseases</i>				
<i>Diabetes</i>				
<i>Fainting/Dizzy</i>				
<i>Hearing Problems</i>				
<i>Heart Disease</i>				
<i>High/Low Blood Pressure</i>				
<i>High/Low Blood Sugar</i>				
<i>Liver Disease, Jaundice</i>				
<i>Major Injuries</i>				
<i>OB/Gyn Problems</i>				
<i>Obesity</i>				

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Seizures/Epilepsy				
Stomach or Intestinal Problems				
Thyroid Problems				
Ulcer				
Vision Problems				

Comments: \_\_\_\_\_

**E. NUTRITION**

Generally good?  Yes  No Special diet? \_\_\_\_\_

**XII. ABUSE HISTORY**

Have you experienced physical, sexual or emotional abuse?  No  Yes

If yes, explain: \_\_\_\_\_

**XIII. LEGAL HISTORY**

A. Do you have any history of legal charges?  No  Yes Explain: \_\_\_\_\_

\_\_\_\_\_

B. Are you currently on probation or parole?  No  Yes If yes, explain: \_\_\_\_\_

Probation officer's name: \_\_\_\_\_

C. Is treatment court ordered? \_\_\_\_\_

**XIV. DESCRIBE ANY OTHER RELEVANT CONCERNS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_  
*Signature of Person Completing Form      Date*

\_\_\_\_\_  
*Relationship to Client*

\_\_\_\_\_  
*Signature of Staff Reviewing      Credentials*

\_\_\_\_\_  
*Review Date*