Social Butterfly Counseling

232 Madison Ave Wyckoff, NJ 07481
(973) 310-2417

Adult Intake Form

General Information

Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email: _____

Referral Source: _____

Emergency Contact: _____

Demographic Information

Ethnic Identity (check and/or circle all that apply)

☐African/African American ☐East Indian/Pakistani ☐Middle Eastern ☐White/Caucasian

☐Asian American/ Chinese/ Filipino/ Japanese/ Korean/ Vietnamese

☐Latino/ Hispanic/ Mexican-American/ Puerto Rican

☐Native American/ Alaskan Native ☐Polynesian/Micronesian

☐Other (specify) _____

How much do you identify with your ethnic heritage? _____

Sexual Orientation: _____

Religious/Spiritual preference: _____

Do you consider yourself a religious person? □ Yes □ No A spiritual person? □ Yes □ No

Faith group/denomination in which you were raised: _____

Current congregation: _____ Level of activity: _____

Family Information

If you have any children, list here:

Name of Child	Date of Birth	Age	Relationship with Child (good, poor, etc.)	Lives with you?
				YES NO
				YES NO
				YES NO
				YES NO

Marital:

Are you currently in a romantic relationship? □ Yes □ No

Marital status (circle): single / married / divorced / remarried / living together

Date of marriage: _____ Date of divorce: _____

Previous marriages/divorces: _____

Custody arrangements: _____

List others who may live with you, including ages, occupations:

_____

_____

_____

Family History

Please select any past, present, or impending social problems in your family:

Family Mental Health History

Please indicate if there is a history of mental health problems in your family. If so, indicate the family member.

	Yes (If yes, who?)	No
Alcohol/Substance Use		
Anxiety		
Depression		
Domestic Violence		
Eating Disorders		
Schizophrenia		
Suicide Attempts		

Health History

Mental health services:

Have you previously received any type of mental health service (psychotherapy, psychiatric services)?

If yes, describe: _____

_____

Psychiatric hospitalizations:

Have you ever been hospitalized for psychological or emotional difficulties?

If yes, describe, including dates and reasons for hospitalization:

_____

_____

_____

Are you currently taking any psychiatric medication? □ Yes □ No

If yes, list below:

Medication	Dosage	Reason	Frequency	Prescribing Physician

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Describe any specific health concerns: _____

_____

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

Describe any specific sleep problems: _____

_____

How would you rate your physical activity level?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Are you experiencing any difficulties with your appetite or eating patterns?

□ Eating less □ Eating more □ Binging (eating larger-than-average amounts in short periods of time)

□ Making self vomit □ Significant weight change in last two months

Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ Yes □ No

Have you had suicidal thoughts recently? □ frequently □ sometimes □ rarely □ never

Have you had suicidal thoughts in the past? □ frequently □ sometimes □ rarely □ never

Please explain more if you checked anything other than never: _____

_____

_____

Have you ever intentionally inflicted any harm upon yourself? □ Yes □ No

Do you drink alcohol more than once a week? □ Yes □ No

If yes, how often? _____

How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

Safety and Trauma

Is there a concern about violence in your life today, either from you or towards you?

If yes, please explain:

_____

_____

_____

_____

_____

How concerned for your safety are you on a scale of 1 to 10, with 10 being the worst? (Circle one):

1 2 3 4 5 6 7 8 9 10

Have you ever experienced any abuse, assault, or harassment?

If yes, identify: □ physical □ emotional □ verbal □ sexual □ other:_____

Describe: _____

_____

_____

_____

_____

In what ways does this impact you today?

_____

_____

_____

_____

Employment

Are you currently employed? Describe employment situation: _____

_____

_____

Is there anything stressful about your work? Describe: _____

_____

_____

Current Reasons for Seeking Counseling

Please describe the reasons you are seeking counseling at this time.

Please briefly describe the history of these concerns, listing all factors that may contribute.

Please list the things you have tried or done to cope with this problem.

What do you hope to accomplish by coming here?

Please describe your strengths.

Please describe your weaknesses.