

**Grace Point Marriage & Family Center**  
**Personal—Adult (18+)**  
**Intake Information**

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:  F  M Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Form completed by (if someone other than client): \_\_\_\_\_

Primary reason(s) for seeking services:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Marital Problems  | <input type="checkbox"/> Parenting                 | <input type="checkbox"/> Relationship     | <input type="checkbox"/> Family          |
| <input type="checkbox"/> Anger management  | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Coping           | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Eating disorder   | <input type="checkbox"/> Fear/phobias              | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Sexual concerns |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Addictive behaviors       | <input type="checkbox"/> Alcohol/drugs    | <input type="checkbox"/> Eating Habits   |
| <input type="checkbox"/> Job               | <input type="checkbox"/> Medical / Health problems |   |  |

Other mental health concerns (specify): \_\_\_\_\_

\*If you need any more space for any of the questions please use the back of the sheet.

**Marital Status**

(more than one answer may apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Single          | <input type="checkbox"/> Divorce in process | <input type="checkbox"/> Unmarried, living together |
|  | Length of time: _____                       | Length of time: _____                               |
| <input type="checkbox"/> Legally married | <input type="checkbox"/> Separated          | <input type="checkbox"/> Divorced                   |
| Length of time: _____                    | Length of time: _____                       | Length of time: _____                               |
| <input type="checkbox"/> Widowed         | <input type="checkbox"/> Annulment          |   |
| Length of time: _____                    | Length of time: _____                       | Total number of marriages: _____                    |

**Religious/Cultural/Ethnic**

To which cultural or ethnic group, if any, do you belong? \_\_\_\_\_

Are you experiencing any problems due to cultural or ethnic issues?  Yes  No

If Yes, describe: \_\_\_\_\_

Other cultural/ethnic information: \_\_\_\_\_

Would you like your spiritual/religious beliefs incorporated into your counseling?  Yes  No

If Yes, describe: \_\_\_\_\_

Do you have a religious affiliation?  Yes  No

If Yes, please explain: \_\_\_\_\_

**Legal**

Are you involved in any criminal proceedings or litigation at the present time?  Yes  No

If Yes, please describe: \_\_\_\_\_

Are you presently on probation or parole?  Yes  No

If Yes, please describe: \_\_\_\_\_



Current prescribed medications	Dose	Length of Time	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Length of Time	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family history of medical problems: \_\_\_\_\_  
 \_\_\_\_\_

Please check if there have been any recent changes in the following:

- Sleep patterns       Eating patterns       Behavior       Energy level  
 Physical activity level       General disposition       Weight       Nervousness/tension

Describe changes in areas in which you checked above: \_\_\_\_\_  
 \_\_\_\_\_

Please tell us about your prior counseling and/or treatment history:

Diagnosis	Yes	No	When	Where	Reason /
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Have any of your family members or significant others had counseling or treatment in any of the above areas?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you drink alcohol?  Yes  No If so, how often and in what quantity?  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you used/abused drugs, alcohol or controlled substances?  Yes  No If yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes  No If Yes, describe: \_\_\_\_\_

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?  Yes  No

If Yes, describe: \_\_\_\_\_

Have drugs or alcohol created a problem for your job/relationship?  Yes  No

If Yes, describe: \_\_\_\_\_

### Behavioral History

Please check behaviors and symptoms that are problematic for you:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aggression         | <input type="checkbox"/> Phobias/fears       | <input type="checkbox"/> Panic attacks          |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Pornography            |
| <input type="checkbox"/> Anger              | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Disruptive thoughts    |
| <input type="checkbox"/> Hallucinations     | <input type="checkbox"/> Sexual addiction    | <input type="checkbox"/> Spending problems      |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Sexual difficulties    |
| <input type="checkbox"/> Avoiding people    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems      |
| <input type="checkbox"/> Chest pain         | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Speech problems        |
| <input type="checkbox"/> Cyber addiction    | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Suicidal thoughts      |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Disorganized thoughts  |
| <input type="checkbox"/> Disorientation     | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Trembling              |
| <input type="checkbox"/> Distractibility    | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Withdrawing            |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Worrying               |
| <input type="checkbox"/> Drug dependence    | <input type="checkbox"/> Mood shifts         | <input type="checkbox"/> Social problems        |
| <input type="checkbox"/> Eating disorder    | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Other (specify): _____ |

Briefly discuss how the above symptoms impact your ability to function: \_\_\_\_\_

---

---

---

---

---

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

Yes  No If Yes, please explain:

---

---

---

### Stress Indicators

Were there special, unusual, or traumatic circumstances that affected you in childhood?  Yes

No

(i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)

If Yes, please describe:

---

---

---

Please check any events that have occurred in the last 12 months:

Moving

Divorce

Financial Problems

Marriage

Car trouble

Birth of a child

Natural disaster

Job Change

Death of a close family  
member/friend