TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

A D U L T I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____ Today's Date: _____/_____/_____
(Last) (First) (MI)

Birth Date: ____ /____ /_____ Age: _____ Gender: □ Male □ Female □ Other _____

Address: _____
(Street and Number) (City) (State) (Zip)

Clinician you are seeing today: _____ Soc. Sec.#: _____-_____-_____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is NOT considered a confidential medium of communication.

Marital Status: (please circle any that apply)

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

_____ Age: _____ Gender: □ Male □ Female □ Other _____
Previous Spouse/Partner

Year of Marriage: _____ If Divorce or Separation date of Divorce/Separation: _____

_____ Age: _____ Gender: □ Male □ Female □ Other _____
Current Spouse/Partner

Children:

Child#1: _____ Age: _____ Child#3: _____ Age: _____

Child#2: _____ Age: _____ Child#4: _____ Age: _____

Employment:

Occupation: _____Employer: _____

Employer Address: _____
(Street and Number) (City) (State) (Zip)

Who referred you to Traverse Counseling & Consulting (if any)?: _____

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Name: _____ Today's Date: _____/_____/_____
(Last) (First) (MI)

Have you previously received any type of mental health services (psychotherapy, psychiatric services, marriage counseling, etc.)? □ No □ Yes, previous therapist/practitioner: _____

_____

Are you currently taking any prescription medication? □ Yes □ No Please list: _____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very good**

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very good**

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

_____

4. Please list any difficulties you experience with your appetite or eating patterns _____

_____

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

If yes, for approximately how long? _____

_____

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

If yes, when did you begin experiencing this? _____

_____

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

If yes, please describe _____

_____

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

Describe your use: _____

_____

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Describe your use: _____

_____

10. How would you describe your digital life? Your relationship to your cell phone, internet, video games, computer, social media, etc. _____

_____

_____

_____

11. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

How would you describe your relationship? _____

_____

12. If you have children, describe your relationship with your children: _____

_____

_____

_____

13. What significant life changes or stressful events have you experienced recently: _____

_____

_____

FAMILY HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Accidental Death	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Divorce/Separation	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Head injury/trauma	yes/no	_____
Obesity	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Other family issues: _____

_____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation:

_____

Do you enjoy your work? What is most stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief _____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

4. What do you consider to be some of your weakness? _____

_____

_____

5. What are your three most important values:

- _____
- _____
- _____

6. What is it that makes you feel *stuck*? _____

_____

7. What would you like to accomplish out of your time in therapy?: _____

_____

_____