TRAVERSE COUNSELING & 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: the 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(s) you are seeing today: _____ Soc. Sec.#: _____-____-_____

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

Cell 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.

Relationship 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)

While some of the following questions may not seem important or pertinent, this questionnaire is an invitation to reflect on your health, your relationships, and the challenges that you are experiencing. We ask that you spend a little time reflecting on these questions and provide the completed questionnaire *directly to your therapist*. Answering the questions helps the therapist(s) that will be supporting you to know and understand your experience with added depth. We are so honored that you have invited us to support you on your journey.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

☐ **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?: _____

In what types of exercise to you participate?: _____

_____

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

_____

5. Have you ever been diagnosed with a medical condition?: ☐ **Yes** ☐ **No** _____

_____

6. Are you currently experiencing feeling (check if applicable):

□ **Overwhelmed** □ **Sadness** □ **Grief** □ **Loss** □ **Depression**

For approximately how long? _____

_____

7. Are you currently experiencing: □ **Anxiety** □ **Panic Attacks** □ **Phobias**

If yes, how long/describe?: _____

_____

8. Are you currently experiencing any chronic pain?: □ **No** □ **Yes**

If yes, please describe _____

_____

9. Do you drink alcohol?: □ **No** □ **Yes** If yes, drinks per week: □ **1-3** □ **4-7** □ **8-14** □ **15-21** □ **21+**

10. Medication/Drugs: Have you *ever* been prescribed psychiatric medication? □ **Yes** □ **No**

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

If yes, what medication(s)? _____

_____

How often do you use non-prescription drugs? □ **Daily** □ **Weekly** □ **Monthly** □ **Infrequently** □ **Never**

Describe your use: _____

Do you use tobacco/vaping? □ **Yes** □ **No**

Describe your use: _____

11. How would you describe your sleep? _____

□ **Enough** □ **Too much** □ **Wake up frequently** □ **Always tired** □ **Well rested**

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

_____

_____

13. Are you currently in a couple 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? _____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

_____

16. Are there things in your family/couple relationship(s) that have been difficult to discuss?

□ **No** □ **Yes** If yes, you may elaborate here, and/or discuss with your therapist:_____

_____

_____

_____

17. Have you previously received any type of mental health services (psychotherapy, psychiatric services, marriage counseling, etc.)?: □ **No** □ **Yes**

Previous therapist/practitioner(s): _____

Year and Dates: _____ Was this a positive experience for you? □ **No** □ **Yes**

Previous goals of therapy:_____

_____

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 _____

Alzheimer's/Dementia yes/no _____

Anxiety yes/no _____

Cancer yes/no _____

Chronic Illness yes/no _____

Depression yes/no _____

Divorce/Separation yes/no _____

Domestic Violence/Abuse yes/no _____

Eating Disorders yes/no _____

Head injury/trauma yes/no _____

Obesity yes/no _____

Schizophrenia yes/no _____

Suicide and/or 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 most important values: _____

_____

_____

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

_____

_____

7. What brought you to therapy?: _____

_____

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

_____