
Family Counseling & Psychology Center, P.C.

2485 Tech Drive

Bettendorf, Iowa 52722

Phone: 563-355-1611 Fax: 563-355-6617

Adult Contact Information

Name: _____ Date: _____

Legal Name (if different): _____

Address: _____ Gender: M F TG

City: _____ State: _____ Zip: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____

Insurance Information

Primary Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Type of Additional Coverage: Secondary EAP (Employee Assistance Program)

Additional Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Contact Telephone Number

Please complete the relevant information and indicate the number at which you wish to be contacted first.

	Phone Message OK?		Primary contact number	Appt. Reminder through
	YES	NO		
Home: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cell: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Email: _____	Ok to email		<input type="checkbox"/> YES	<input type="checkbox"/> NO

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Name: _____ D.O.B. _____ ID # _____

Marital Status

- Single Divorced (____years) Living as Married (____years)
 Married (____years) Separated (____years) Widowed (____years)

Spouse's/Partner's Name: _____

If FCPC is unable to reach you, is it OK to contact your spouse/partner? YES NO

Employment Status

Are you employed? YES NO Are you using EAP? YES NO

Employer Name: _____

Emergency Contact Information

Name: _____

Address: _____

Phone: () _____ - _____ Relationship to you: _____

Primary Care Physician

Current Physician: _____

Physician Address: _____

Physician Phone Number: () _____ - _____

Physician Fax Number: () _____ - _____

Referent

By whom were you referred? _____

Family Counseling & Psychology Center, P.C.

Name: _____ D.O.B. _____ ID # _____

Adult Intake Form

Presenting Problems and Concerns

Describe the problem that brought you here today: _____

Please check all of the behaviors and symptoms that you consider problematic:

- | | | |
|------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Increased Libido |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Decreased need for sleep |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety/worry | <input type="checkbox"/> Increased risky behavior |
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Wide mood swings |
| <input type="checkbox"/> Poor memory/confusion | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Seasonal mood changes | <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Sadness/depressed mood | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Aggression/fights | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Frequent arguments | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Increased irritability/anger | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Low self worth | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Guilt/shame | <input type="checkbox"/> Visual hallucinations | <input type="checkbox"/> Recurring, disturbing memories |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Suspicion/paranoia | <input type="checkbox"/> Viewing Pornography |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | |

Are your problems affecting any of the following?

- | | | | |
|--------------------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Handling everyday tasks | <input type="checkbox"/> Self esteem | <input type="checkbox"/> Relationships | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Work/School | <input type="checkbox"/> Housing | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Recreational activities | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Health | |

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Name: _____ D.O.B. _____ ID # _____

Yes No Have you ever had feelings or thoughts that you didn't want to live? If yes, please describe: _____

If yes to the above.....

- How often do you have these thoughts? _____
 - When was the last time you had these thoughts of dying? _____
 - Has anything happened recently to make you feel this way? _____
 - On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill yourself currently? _____
 - Would anything make it better? _____
 - Have you ever thought about how you would kill yourself? _____
 - Is the method you would use readily available? _____
 - Have you planned a time for this? _____
 - Is there anything that would stop you from killing yourself? _____
 - Do you feel hopeless and/or worthless? _____
 - Have you ever tried to kill or harm yourself before? _____
 - Do you have access to guns? _____ If yes, please explain _____
-

Yes No Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

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Name: _____ D.O.B. _____ ID # _____

Yes No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

If yes to the above.....

- How often do you have these thoughts? _____
- On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill someone else currently? _____
- Have you ever thought about how you would kill someone else? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm someone else before? _____
- Do you have access to guns? _____ If yes, please explain _____

Therapist Notes:

Please check if you have experienced any of the following types of trauma or loss:

- | | | |
|-------------------------------------------------|-----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Violence in the home | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Crime victim | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Parent illness | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Parent substance abuse | <input type="checkbox"/> Place a child for adoption | <input type="checkbox"/> Miscarriage/Stillborn |
| <input type="checkbox"/> Teen pregnancy | <input type="checkbox"/> Lived in a foster home | |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Multiple family moves | |

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Name: _____ D.O.B. _____ ID # _____

Please note if any family members have experienced any of the following mental health problems.

Family Mental Health History	Who?
ADHD	
Experienced Sexual Abuse	
Depression	
Bipolar Disorder	
Made Suicide Attempt	
Anxiety Problems	
Panic Attacks	
Obsessive-Compulsive Behavior	
Anger Problem/Abusive Behavior	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Autism	
Self Harm Behavior	
Other	

Family Background and Childhood History:

- Were you adopted? Yes No
 - If Yes at what Age _____
- Where did you grow up? _____
- What was your father's occupation? _____
- What was your mother's occupation? _____
- Did your parents' divorce? Yes No If so, how old were you? _____
- If your parents' divorced, who did you live with? _____
- Describe your father, and your relationship with him: _____

- Describe your mother, and your relationship with her: _____

- How old were you when you left home? _____
- Has anyone in your immediate family died? _____ Who and when: _____

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Name: _____ D.O.B. _____ ID # _____

Relationship History and Current Family:

Are you currently: Married Partnered Divorced Single Widowed

How long: _____

If not married are you currently in a relationship? Yes No If yes, how long? _____

Are you sexually active? Yes No

How would you identify your sexual orientation?

straight/heterosexual lesbian/gay/homosexual bisexual transsexual
 unsure/questioning asexual other prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? Yes No If so, how many? _____ For how long? _____

Do you have children? Yes No If yes, list ages and gender: _____

Describe your relationship with your children: _____

List everyone who currently lives with you: _____

Previous Mental Health Treatment

YES	NO	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Therapist Notes:

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Name: _____ D.O.B. _____ ID # _____

Substance Use History

- Tobacco
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Caffeine
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Alcohol
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Marijuana
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Cocaine/Crack
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Ecstasy
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Heroin
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Inhalants
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Methamphetamines
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Pain Killers
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- PCP/LSD
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Steroids
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____
- Tranquilizers
 - Current Use (last 6 months) Yes No Frequency _____ Amount _____
 - Past Use Yes No Frequency _____ Amount _____

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Name: _____ D.O.B. _____ ID # _____

Have you had withdrawal symptoms when trying to stop using any substances? Yes No

If yes, please describe: _____

Have you gambled in the past 6 months? Yes No If yes, let us know the following:

Have you ever felt the need to bet more and more money? Yes No

Have you ever had to lie to people important to you about how much you gambled? Yes No

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?

Yes No

If yes, please describe: _____

Therapist Notes:

Medical Information

Date of last physical exam: _____

Personal and family medical history:

- | | | |
|-------------------------------------------------------|-------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Surgery | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Abortion | <input type="checkbox"/> Head injury/Trauma |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Asthma/respiratory problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |

Personal and Family Medical History:

	Yes	No	Which Family Member
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Stomach or intestinal problems			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Liver Problems			
Other			

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Please list any CURRENT health concerns: _____

Past medical problems, surgeries, or non psychiatric hospitalization: _____

Add additional personal or family history: _____

Current prescription medications: None

Medication	Dosage	Date First Prescribed	Prescribed By	Taken For

Current over-the-counter medications or supplements (including vitamins, herbal remedies, etc.):

Allergies and/or adverse reactions to medications: None
If yes, please list: _____

Therapist Notes:

Interpersonal/Social/Cultural Information:

Please describe your social support network (check all that apply)

- Family Neighbors Support/Self-Help Group Friends Students
 Community Group Co-Workers Religious/Spiritual Center (which one) _____

To which cultural or ethnic group do you belong? _____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: _____

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Name: _____ D.O.B. _____ ID # _____

How important are spiritual matters to you? Not at all Little Somewhat Very much

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

Please describe your strengths, skills, and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

Therapist Notes:

Miscellaneous Information

Employment:

Employer: _____ Position: _____

Length of time in this position: _____ Job Duties: _____

Stress level of this position: Low Medium High

Other jobs you have held: _____

Education:

Are you currently attending school? Yes No

	Yes	No	Year Graduated	Major of Study	School Attended
High School Graduate					
GED					
Associate's Degree					
Undergraduate Degree					
Graduate Degree					

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Name: _____ D.O.B. _____ ID # _____

Military Service:

Have you been/are you currently in the military? (if no skip remainder of this section) Yes No

Branch _____ Date of Discharge _____ Type of Discharge _____

Rank _____ Were you in combat? Yes No

Legal:

Have you ever been arrested? Yes No

Do you have any pending legal problems? Yes No

Have you ever been convicted of a misdemeanor or felony? Yes No If yes, please explain: _____

Are you currently involved in any divorce or child custody proceedings? Yes No

If yes, please explain: _____

Therapist Notes:

Signature: _____ Date: _____