NOLA Counseling Center
701 Papwoth Street Suite 209
Metairie, LA 70001

Adult Intake Form

Date: ____/_____/____

Client Information

Name:_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email Address:_____

Preferred Method of Contact:
☐ Call ☐ Text ☐ Email

US Citizen? ☐ Yes ☐ No

If no, immigration Status: _____
DOB: ____/_____/____

Age: _____
Marital Status: ☐ Married ☐ Single
☐ Cohabitating ☐ Separated ☐ Divorced
How did you hear about us?
☐ Goodtherapy.org ☐ Psychology Today
☐ Website ☐ Friend/ Family
☐ Other (Specify)_____
Schooling (highest level Completed):
☐ Elementary School ☐ Trade School
☐ High School ☐ GED
☐ College
☐ Post College

Emergency Contact

Name:_____ Number: _____ Relationship: _____

Name:_____ Number: _____ Relationship: _____

Current Employment: Where_____ Position _____

If Unemployed, why? _____

Persons Living With You:

Name	Age	Relationship

Presenting Problem

Briefly describe your current difficulties

_____

_____

_____

How long has this problem been of concern to you and what made you come to counseling at this time?

_____

_____

What seems to help this problem?

_____

What seems to make this problem worse?

_____

Have any other family members had similar problems?

☐ Yes ☐ No- If yes, details: _____

Have received a psychological evaluation or treatment for the current problem, or similar problems in the past?

☐ Yes ☐ No- If yes, when and with whom? _____

Describe and major event(s) that might be related to the problem (e.g., death, divorce, abuse, etc.)

_____

_____

_____

_____

_____

How do you hope counseling can help? _____

_____

_____

Medical History

When was your last physical exam? _____

Physician's name and address: _____

Physical condition/ diagnosis: _____

Any major childhood illnesses? _____

Current medications:

Medications	Length of Time	Condition being Treated
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medications for mental disorders: _____

Have you ever be hospitalized for mental illness? ☐ Yes ☐ No- If yes, please explain. _____

_____

Do you currently have suicidal thoughts? ☐ Yes ☐ No

If so, frequency: _____ Means: _____ Plan ☐ Yes ☐ No

Do you currently have thoughts of harming others? ☐ Yes ☐ No

If so, frequency: _____ Means: _____ Plan ☐ Yes ☐ No

Substance Use

☐ Caffeine Frequency: _____

☐ Alcohol Frequency: _____

☐ Tobacco Frequency: _____

☐ Marijuana Frequency: _____

☐ Other: _____

Recovering alcoholic? ☐

Recovering drug addict? ☐

Family history of alcoholism? ☐

Family history of drug abuse? ☐

Needle use? ☐ Yes ☐ No HIV Test? ☐ Yes ☐ No

Date: _____ Result: _____

Previous Treatment for alcohol/ drug abuse?

☐ Yes ☐ No

Treatment facility: _____

Dates: _____

Hepatitis test? ☐ Yes ☐ No

Date: _____ Result: _____

Comments:

_____

_____

_____

_____