***R & R Restoration Ministry***
**Adult Intake Form**

Instructions: Please complete the survey as accurately as possible, including any information that you feel could benefit the counseling process. All information contained in this survey is confidential except as prohibited by state / federal law regarding major criminal offenses and child, elderly, or disabled persons abuse.

## PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____
Mailing Address City / State / Zip Code

Telephone: (home) _____ (cell) _____

Email address: _____

Employer: _____
Name of Company

Current Profession: _____

Age:_____ Marital Status __ Single __ Married __Divorced
__ Remarried __ Widowed

Children (You do not need to include child's name):
1) _____ 4) _____
gender / age / currently living in the home gender / age / currently living in the home
2) _____ 5) _____
gender / age / currently living in the home gender / age / currently living in the home
3) _____
gender / age / currently living in the home

## EMERGENCY INFORMATION

In case of an emergency contact:
Name: _____ Relationship: _____

Address: _____
Mailing Address City / State / Zip Code
Telephone:(home) _____ (work) _____ (cell) _____

## REASON FOR SEEKING COUNSELING

What specific issue(s) in your life are your hoping will be addressed through the counseling process?

_____
_____
_____
_____

**FAMILY BACKGROUND**
**Parents:**
Are your parents living?
Father: Yes _____ No _____ Your age at time of death: _____
Mother: Yes _____ No _____ Your age at time of death: _____

Are they Living Together? Yes _____ No _____

Divorced? Yes _____ No _____ How old were you when they divorced? _____
Remarried? _____
Father: Yes _____ No _____ Your age at time of remarriage: _____
Mother: Yes _____ No _____ Your age at time of remarriage: _____

Was your relationship with your mother: close _____ distant _____conflicted _____
Was your relationship with your father: close _____ distant _____conflicted _____

Siblings (You do not need to include siblings' name):
1) _____ 4) _____
gender / age gender / age
2) _____ 5) _____
gender / age gender / age
3) _____
gender / age

Where do you fall in the birth order? _____

How was your relationship with your siblings growing up?

Close _____ Distant _____ Conflicted _____

Was yours a basically happy or unhappy home during childhood?_____

Were there any instances of abuse in your family?

| | | By Whom? | Abuse Directed Toward? |
|---|---|---|---|
| Verbal | Yes_____ No _____ | _____ | _____ |
| Emotional | Yes _____ No _____ | _____ | _____ |
| Physical | Yes_____ No _____ | _____ | _____ |
| Sexual | Yes _____ No _____ | _____ | _____ |
| Alcohol (Including substance abuse) | Yes _____ No _____ | _____ | _____ |

Other problems not mentioned _____

## SPIRITUAL HISTORY

Note: The counseling provided will be conducted from a faith-based perspective. While the counselee does not have to be of the Christian faith, they understand that issues of faith will be an important component of the counseling process.

What is your religious or church background? _____

Are you currently active in your church? _____

How would you describe your relationship with God? _____
_____
_____

## MOOD INVENTORY

Do you have any of the following symptoms:

| | Yes | No |
|---|---|---|
| 1. Change in eating habits (poor appetite/overeat)? | __ | __ |
| 2. Change in sleeping patterns (insomnia/oversleeping)? | __ | __ |
| 3. Have a lack of motivation/energy for ordinary tasks? | __ | __ |
| 4. Have feelings of hopelessness? | __ | __ |
| 5. Have poor concentration and difficulty making decisions? | __ | __ |
| 6. Have you ever been diagnosed with: | | |
| depression | __ | __ |
| schizophrenia | __ | __ |
| obsessive compulsive disorder | __ | __ |
| attention deficit disorder | __ | __ |
| anxiety disorder | __ | __ |
| bipolar | __ | __ |
| other (please describe) _____ | | |
| 7. Have you personally ever received psychiatric treatment? | __ | __ |
| 8. Has any member of your family ever received psychiatric treatment? If yes, who and what was the diagnosis: _____ | __ | __ |
| 9. Feel mentally confused? | __ | __ |
| 10. Self medicate (through alcohol, sex, food, work, entertainment, etc.)? | __ | __ |
| 11. Have short term memory loss? | __ | __ |
| 12. Have panic attacks? | __ | __ |
| 13. Hear voices in your head? | __ | __ |
| 14. Are you now undergoing psychiatric treatment? | __ | __ |
| 15. Are you currently on medications? If so, which ones? _____ | __ | __ |

**ADDICTION INVENTORY**

Have you ever been addicted to any of the following:

| | Currently | In the Past |
|---|---|---|
| alcohol | Yes _____ No _____ | Yes _____ No _____ |
| substances | Yes _____ No _____ | Yes _____ No _____ |
| tobacco | Yes _____ No _____ | Yes _____ No _____ |
| food | Yes _____ No _____ | Yes _____ No _____ |
| gambling | Yes _____ No _____ | Yes _____ No _____ |
| pornography | Yes _____ No _____ | Yes _____ No _____ |
| sex | Yes _____ No _____ | Yes _____ No _____ |

other (please list) _____

Has anyone in your family been addicted to any of the above?
If so, which ones and by whom? _____
_____

**PERSONAL INVENTORY**

Describe yourself in as many one or two word phrases as possible:

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

**ADDITIONAL INFORMATION**

Please describe any additional information that you feel is important to the counseling process. _____
_____
_____
_____
_____
_____

**PAYMENT INFORMATION**

Payment for counseling services is due upon receipt of services. The standard fee is $85.00 per session unless prior arrangements have been made. Cancellations not made 24 hours in advance may result in a $30.00 cancellation fee.

_____ _____
Signature Printed Name

_____
Date