Psychological Services Clinic at UNC

serving the Greeley community for over 50 years

ADULT CLIENT INTAKE

Please provide the following information for our records. Leave blank any question you prefer not to answer.

Name: _____ Date: _____

Permanent Address: _____

Phone: _____Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity: _____ Sexual Orientation: _____

If you are a student what is your year? _____ Major: _____

Relationship Status: _____ Number of Children: ____ Number of children living in the home: ___

Referred by: _____ Are you currently receiving counseling services elsewhere? □Yes □No

Have you had previous counseling? □Yes □No

Do you consider yourself to be religious? □Yes □No If yes, what is your faith? _____

Do you consider yourself to be spiritual? □Yes □No

Are you currently employed outside the home? □Yes □No

What is your occupation? _____

What are your living arrangements? □ alone □ with roommate (s) □ with spouse/partner

□with children □ with family

Are you satisfied with your living arrangements? □Yes □ No

Family Information: Please include all significant family members (feel free to continue on the back)

Name	Age	Relationship	Do they live with you?

Does your family have a history of any of the following?

___Depression ___Anxiety ___Panic attacks ___Alcohol/drug use

___Eating disorders ___Abuse ___Bipolar Disorder ___Schizophrenia

___Other mental health concerns (_____) ___Attempted or completed suicide

Family Relationships:

__My parents are divorced/separated __My family is not emotionally close.

How would you describe your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, diabetes, etc.)

_____

Are you having any problems with your sleep habits? □Yes □No If yes, please describe

_____

Are you having difficulty with appetite or eating habits? □Yes □No

If yes, check where applicable □Eating less □Eating more □Binging □Restricting □Other

Are you currently taking any prescribed psychiatric mediation (antidepressants or others)?

□Yes □No If yes, please list: _____

Do you regularly use alcohol? □Yes □No If yes, how frequently and how much? _____

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

Daily Weekly Monthly Rarely Never

Have you ever felt that your substance (alcohol or drug) use was a problem? □Yes □No

What substance(s) do you use? _____

Has anyone ever told you they were concerned about your substance use? □Yes □No

Have you had thoughts of suicide recently (past two weeks)? □Yes □No

If yes, please describe_____

Have you had them in the past? □Yes □No

If yes, please describe_____

Have you ever attempted suicide? □Yes □No

If yes, please describe_____

Have you ever had thoughts of harming other people? □Yes □No

If yes, please describe_____

In the last year, have you experienced any significant life changes or stressors? □Yes □No

If yes, please explain_____

Have you ever experienced problems with:

___Depression ___Anxiety ___Panic attacks ___Mood swings ___Anger

___Repetitive thoughts ___Repetitive behaviors ___Racing thoughts ___Abuse

___Difficulty concentrating or focusing ___Confusing thoughts

Please check the statements that apply to you:

___I do not have close friends I can talk to about personal issues
___I have a good social support system
___My relationship with my family is satisfactory

___I have difficulty handling stress
___I have difficulty expressing my emotions
___I often get extremely angry
___At times I have acted in a violent manner
___I am having academic or work problems
___I have suffered a recent loss: ___ death ___ relationship ending ___ other loss: _____
___I have current or past health concerns I would like to discuss
___I have sexual concerns I would like to discuss

Please give the name and phone number of an Emergency Contact:
Name:_____ Phone: _____
Do we have your permission to contact this person if we feel it is necessary?
□Yes □No

What are some of your strengths?

_____

_____

_____

_____

_____

_____

What would you like to accomplish in counseling? Please list your goals.

_____

_____

_____

_____

_____

_____

Master's and doctoral students in our graduate programs staff the Psychological Services Clinic (PSC). To insure the quality of services you receive, all counselors in training are assigned faculty supervisors with whom to consult concerning the progress of counseling. Your session may be both audio and visually recorded. The purpose of recording is to provide instruction and feedback to students. All recorded materials and written records are restricted to the internal use of the PSC and their confidentiality will be strictly safeguarded, with exceptions discussed with your counselor in the first session. Recordings are deleted after 90 days.