

CHESAPEAKE LIFE CENTER  
**COUNSELING INTAKE FORM –ADULT**

Office use  
only

CLC Client Id#: \_\_\_\_\_ Intake Date: \_\_\_\_\_  
Office: AA PG Other \_\_\_\_\_  
Source: HOC Community \_\_\_\_\_

**PERSONAL INFORMATION**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Years: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_  
Phone: 1. \_\_\_\_\_ 2. \_\_\_\_\_

**CURRENT FUNCTIONING AND COUNSELING GOALS**

I have experienced the following changes since my loved one died:

- Appetite: Less than usual No change More than usual Uncertain  
Sleep Patterns: Sleeping less than usual No change Sleeping more than usual every day Uncertain  
Feeling sad or empty: Never Occasionally Frequently Nearly every day Constantly  
Feeling fatigued or low energy: Never Occasionally Frequently Nearly every day Constantly  
Diminished ability to think or concentrate or indecisiveness nearly every day: Yes No Uncertain  
Having recurring thoughts of suicide: Never Occasionally Frequently Nearly every day Constantly  
Reduced interest or pleasure in all or most activities: Never Occasionally Frequently Nearly every day

What are your goals or hopes for grief counseling? \_\_\_\_\_

**LOSS HISTORY**

Name of person you are grieving: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Loss: \_\_\_\_\_

The circumstances leading to the death: \_\_\_\_\_

Did you have the opportunity to say goodbye: Yes No Uncertain

Describe your relationship prior to the death: Loving Distant Mixed Feelings Other: \_\_\_\_\_

Do you feel that you have been able to cope with other losses/major changes?: Yes No Uncertain

**EMOTIONAL AND SPIRITUAL SUPPORT SYSTEMS**

With whom do you live: \_\_\_\_\_

When I am sad, I talk to \_\_\_\_\_

I know I can count on \_\_\_\_\_

I draw hope from: family friends faith/spiritual practice Higher Power/God readings  
Other: \_\_\_\_\_

My main support is/are: family friends faith/spiritual community prayer  
Other: \_\_\_\_\_

I believe I am involved in the following meaningful activities: \_\_\_\_\_

Are you currently a member of or active in a faith community: Yes No

Faith/spiritual tradition practiced: \_\_\_\_\_

## COUNSELING HISTORY

Have you ever received counseling before?  Yes  No

If yes, for what: \_\_\_\_\_ When: \_\_\_\_\_ Was it helpful:  Yes  No

Have you ever been treated for depression or anxiety?  Yes  No

If yes, please describe: \_\_\_\_\_ When: \_\_\_\_\_ Was it helpful:  Yes  No

Is there any family history of drug/alcohol misuse?  Yes  No

If so, who: \_\_\_\_\_ Treatment was received:  Yes  No

Is there any family history of sexual or physical abuse?  Yes  No

If so, who?: \_\_\_\_\_ Treatment was received:  Yes  No

Have you had any family members die by suicide?  Yes  No

Please share anything else that you would want to share about your counseling history:

\_\_\_\_\_

\_\_\_\_\_

## FAMILY HISTORY

Relationship Status:  Single  Married  Partnered  Divorced  Separated  Widowed

Spouse/Partner

Name: \_\_\_\_\_ Years together: \_\_\_\_\_ Living:  At home  Away  Deceased: \_\_\_\_\_

Children:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Living:  At home  Away  Deceased: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Living:  At home  Away  Deceased: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Living:  At home  Away  Deceased: \_\_\_\_\_

Parents:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Living  Deceased: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Living  Deceased: \_\_\_\_\_

Siblings:

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Living  Deceased: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Living  Deceased: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_  Living  Deceased: \_\_\_\_\_

## MEDICAL HISTORY

Family Physician: \_\_\_\_\_

Do you have any medical problems that require treatment at this time?:  Yes  No

Please describe: \_\_\_\_\_

Are you currently taking any prescription drugs?:  Yes  No

Name: \_\_\_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Purpose: \_\_\_\_\_

Do you use non-prescription drugs / health supplements? :  Yes  No

Name: \_\_\_\_\_ Purpose: \_\_\_\_\_

Name: \_\_\_\_\_ Purpose: \_\_\_\_\_

Do you drink alcohol?  Yes  No

Please indicate how often:  1 or 2 drinks a month  1 or 2 drinks a week  2 or more drinks a day