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: _____

Continued on other side

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