CHESAPEAKE LIFE CENTER
COUNSELING INTAKE FORM –ADULT

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: ________________________________

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