



The Refuge Center  
FOR COUNSELING



# BANE BOW

## Adult Client Intake Form

### Demographics

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email: \_\_\_\_\_ Method of contact: Phone or Email (circle one)

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ Race: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Single Married (\_\_\_\_ years married) Divorced Widowed (circle one)

Children:	Name	Age
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Referred by: \_\_\_\_\_

- Therapist  Church  Physician  Agency  Friend  Internet

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Previous Counseling

Have you had any previous counseling?  Yes  No

Name of therapist: \_\_\_\_\_ Date of counseling: \_\_\_\_\_

Would you be willing to sign a release of information to talk with previous counselor?  Yes  No

**Medical/Mental Health Information**

Physician: \_\_\_\_\_ Location: \_\_\_\_\_

Are you currently taking medication for a mental or emotional condition?  Yes  No

Please list conditions and medications: \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized for a mental or emotional condition?  Yes  No

If so, please list where and when: \_\_\_\_\_

\_\_\_\_\_

Current medical health problems and medications: \_\_\_\_\_

\_\_\_\_\_

Are you on disability?  Yes  No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you currently use:  Alcohol or  Drugs

Never Rarely Socially Frequently Daily (circle one)

Are you in treatment (such as outpatient) or utilizing support groups (such as AA)?  Yes  No

If yes, please describe: \_\_\_\_\_

What types of self-care practices have been helpful to you in the past when dealing with difficult situations?

*These may be things you learned from previous therapy or discovered on your own. Examples: journaling, exercising, workbooks, prayer, support groups*

\_\_\_\_\_

What are some of your hobbies/interests? \_\_\_\_\_

**Reasons for Seeking Counseling**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In a few words, what do you think therapy is all about? \_\_\_\_\_

\_\_\_\_\_

How long do you think therapy should last? \_\_\_\_\_

How long are you able to commit to therapy? \_\_\_\_\_

What personal qualities do you think the ideal therapist should possess? \_\_\_\_\_

\_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_