Prana Counseling Services, LLC

Adult/Family Intake Form

Thank you for taking the time to complete this form completely and thoroughly. This form has been designed to provide necessary information to Prana Counseling Services, LLC before our initial visit in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information that you think may be helpful to me in understanding you and/or family. All information provided by you is strictly confidential and will not be released to anyone without your written consent.

GENERAL INFORMATION

Today's Date:_____Person Completing Form: _____

How did you hear about Prana Counseling Services? Circle one:
Family member Friend Internet Other Therapist Other Clinic
Doctor Other: _____

Home Address:_____

City_____State_____Zip_____

Your Date of Birth:_____Age:_____

Sex (how do you identify?): _____ Race: _____

Religion:_____ Email: _____

Home Number: _____ Okay to leave a message? Y or N

Work Number:_____ Okay to leave a message? Y or N

Cell Number: _____ Okay to leave a message? Y or N

Occupation: _____ Place of Employment:_____

_____ Relationship Status: _____

FAMILY SYSTEM INFORMATION

NAME	AGE	DOB	RELATIONSHIP	HOW DO THEY GET ALONG IN FAMILY?	ADDITIONAL INFORMATION

CURRENT SYMPTOMS

Please describe why you are seeking therapy services for you (and family if that is applicable) at the present time.

Current/Past Stressors

Please Circle any of the stressors you or your family members have experienced over the past 12 months. You will be asked to elaborate on the circled stressors below.

Divorce	Substance Abuse	Death of a Loved One
Blended Family	Job Loss	Sexual Abuse
Physical Abuse	Neglect	Domestic Violence
Physical Health	Birth of a Child	Change in Financial Status
College	Raising Teens	Job Change
Sexual Performance	Change in Residence	Vacation
Friends	Social Media	Body Image
Sleeping Disturbances	Mental Health of a Family member	School
Social Encounters	Change in Living Condition	Sexual Identity

Other:_____

Please tell me more about any circled stressors above:_____

_____

_____

_____

How long have you been experiencing these problems? _____

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

If married, how long have you been married? _____

If divorced, how long have you been divorced?_____

If divorced, who has physical custody?_____ Is it full or joint? _____

Who has legal custody? _____ Is it full or joint? _____

PLEASE PROVIDE A COPY OF THE CUSTODY AGREEMENT

MENTAL HEALTH HISTORY

Please circle all that apply to you or your family members:

Addictive Behaviors	Agitation	Aggressive Behavior	Anger and Rage
Anorexia	Anxiety	Attachment Problems	Body tension
Bulimia	Chronic Fatigue	Compulsive behavior	Conflict with peers
Constipation	Depression	Despair	Difficulty Sleeping
Dissociative Episodes	Early Trauma	Emotional Expression	Emotionally Reactive
Emotionally Overwhelmed	Fear and Anger	Fibromyalgia	Headaches/Migraines
Hyper-vigilance	Impulsivity	Irritability	Irritable Bowel
Lacking Boundaries	Mental Calming	Mood Swings	Motivation
Nightmares	Night Terrors	Obsessive Negative Thoughts	Obsessive Worry
Panic Attacks	Paranoia	Perfectionism	Phobias
Physical Tension	Poor Concentration	Seizures	Self-Esteem
Self-Injurious Behavior	Sexual Concerns	Erectile Dysfunction	Short-Term Memory Loss
Sleep Walking	Stomachaches	Suicidal Thoughts	Trauma
Verbal Expression	Vertigo	Withdrawn	Working Memory

Other:_____

Which of the above behaviors are the most concerning to you? Why? _____

_____

_____

MEDICAL HISTORY

Primary Care Provider:_____

Medications you (or your family member) are currently taking?:_____

Have you (or your family member) previously attended therapy? Y or N
If Yes, for what reason? _____

How was your experience (circle one)? Helpful Somewhat Helpful
Not Helpful

Have you (or any family member) ever experienced any of the following? Please circle one and describe.

Chronic illness:_____

Surgeries: _____

Hospitalizations:_____

High Fevers:_____

Head Injuries:_____

Seizures: _____

Eating Problems:_____

Sleeping Problems:_____

Enuresis:_____

Intimacy Problems: _____

Other: _____

Is there any other information that would be important for me to know about you or your family?_____

Signature of Client:_____ Date:_____

Signature of Therapist: _____ Date: _____