ROOTED WINGS, LLC
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INTAKE - ADULT

Client Information

1. **Please enter your information.**

First Name | Middle Initial | Last Name | Date of Birth

Address | Apt./Unit #

Social Security Number | Gender ○ Female ○ Male | Email

Cell Phone | Home Phone | Work Phone

OK to leave message on cell phone? ○ Yes ○ No

OK to text message to cell phone? ○ Yes ○ No

OK to leave message on home phone? ○ Yes ○ No

Employment Status

○ Employed, Full-time 35+ hrs/wk ○ Employed, Part-time <35 hrs/wk ○ Unemployed, In treatment
○ Unemployed, Looking for work ○ Unemployed, Not looking for work ○ Not in Labor Force, Child care
○ Not in Labor Force, Disabled ○ Not in Labor Force, Retired ○ Not in Labor Force, Student
○ Not in Labor Force, Other

Employer | Job Title

Student Status
○ Full-time ○ Part-time
○ NA

Name of Current School | Current Grade in School | Highest Grade/Degree Completed

How Did You Hear About My Practice?

☐ Former/Current Client ☐ Website ☐ Internet Search ☐ Healthcare Professional
☐ Mental Health Provider ☐ Insurance Company ☐ Word of Mouth ☐ Other

Primary Insurance Company | Primary Insurance Policyholder | Primary Ins Policyholder's DOB

Primary Insurance ID#

Primary Insurance Group#

Client Relationship to Insured

Secondary Insurance Company

Secondary Insurance Policyholder

Secondary Ins Policyholder's DOB

Secondary Insurance ID#

Secondary Insurance Group#

Client Relationship to Insured

Responsible Party Name

Responsible Party Relationship to Client

Responsible Party Address

Resp Party Cell Phone

Resp Party Home Phone

Emergency Contact Name

Emergency Contact Relationship to Client

Emergency Contact Phone#

Emergency Contact Address

Mental Health History

2. **Please enter your psychotherapy/counseling information.**

What brings you to psychotherapy/counseling at this time?

What would you like to accomplish in psychotherapy/counseling?

Past counseling services?
○ Yes ○ No

If yes, please describe when/where/reason

Are you currently, or were you previously, under the care of a psychiatrist?
○ No ○ Yes

Psychiatrist Phone#

Mental health hospitalizations?
○ Yes ○ No

If yes, please describe when/where/reason

Do you currently have, or have you had, a mental health diagnosis? If yes, please specify

Is there a family mental health history including suicide?
○ Yes ○ No

If yes, specify who and type of mental health issue

Medical Information

3. **Please enter your medical information.**

Primary Care Physician

Primary Care Physician Phone#

Please list any medical problems

Please list current medications including name of medication, dosage, how taken, and what prescribed for

Family History

4. Please provide your family information.

Important individuals present during childhood & adolescence (check all that apply)
☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Sister(s) ☐ Brother(s) ☐ Aunt(s) ☐ Uncle(s) ☐ Other

Please list birth order for you and your siblings

Parents current marital status
☐ Married to each other ☐ Separated ☐ Divorced ☐ Mother remarried ☐ Father remarried ☐ Mother involved w/ someone ☐ Father involved w/ someone

Mother living?
○ Yes ○ No

Your age at Mom's death

Father living?
○ Yes ○ No

Your age at Dad's death

How would you characterize your family's socioeconomic status?
○ Wealthy ○ Poor ○ Upper Middle Class ○ Middle Class ○ Lower Middle Class

Describe your childhood experience (check all that apply)
☐ Loving/Supportive ☐ Stable ☐ Little memory of it ☐ Verbally abusive ☐ Emotionally abusive ☐ Physically abusive ☐ Conditional ☐ Chaotic ☐ Unstable ☐ Parents argued ☐ Domestic violence

Trauma/Abuse History

5. Please enter any trauma/abuse information.

Have you ever been abused?
○ Yes ○ No

If yes, specify type (check all that apply)
☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal ☐ Neglect

Have you experienced any of these issues with stressors? (check all that apply)
☐ Crime victim ☐ Homelessness ☐ Discrimination ☐ Ethnicity/Race ☐ Economic/Financial problems ☐ Gender ☐ Sexuality ☐ Religious ☐ Culture ☐ Other

Any major losses/separations from family members or significant persons?
○ Yes ○ No

If yes, please describe

Other traumas? Please specify what and when it occurred.

Substance Use History

6. **Please enter your substance use/history information.**

Do you currently use any of these substances?
☐ Alcohol ☐ Marijuana ☐ Inhalants ☐ Steroids
☐ Caffeine
☐ Sedatives (Benzodiazepines, Barbituates)
☐ Stimulants (Crack, Cocaine, Methamphetamines, Speed)
☐ Hallucinogens (LSD, Mushrooms, Mescaline)
☐ Opiates (Heroine, Codeine, Morphine) ☐ Nicotine
☐ Other

If currently using substance(s), please specify how much, how often, and date of last use

If not currently using substance(s), did you previously do so? If yes, please describe the prior substance use

Does anyone in your family have a substance abuse problem?
○ Yes ○ No

If yes, please specify who and substance used

Interpersonal/Social/Cultural Information

7. **Please enter your information.**

Describe your strengths, skills, talents

Please describe your social support network (check all that apply)
☐ No friends ☐ Few friends ☐ Family ☐ Neighbors ☐ Co-workers ☐ Support Group ☐ Self-help group
☐ Religious/Spiritual center ☐ Community group ☐ Distant from family of origin ☐ Other

Are you experiencing any difficulties due to cultural/ethnic issues? If yes, please describe

Describe your areas of special interests, hobbies, etc.

Please describe activities you are involved in

Religious upbringing?
○ Yes ○ No

Childhood affiliation

Current affiliation

How important are spiritual matters to you?
○ Not at all ○ Little ○ Somewhat
○ Very much

Please describe why or why not?

Would you like spiritual/religious beliefs to be incorporated into your counseling?
○ Yes ○ No

Please describe any additional information that you feel important for the counselor to know