NEW ROOTS
counseling

ADULT INTAKE ASSESSMENT FORM

Luke Morrissey, EdS, LPC
Licensed Professional Counselor
2025 Ebenezer Rd, Suite M1, Rock Hill, SC 29732-2255
Phone: (803) 325-2255 | E-mail: luke@newrootscounseling.co

IDENTIFYING INFORMATION

Client's name: _____
Today's date: _____ Date of birth: _____ Age: _____Race/ethnicity: _____
Person(s) completing this form: _____
Who suggested that you contact me?_____

CLIENT'S INFORMATION

Home Address: _____
City _____ State _____ Zip Code _____
Home Telephone: _____ Other Phone (specify type): _____
Cell phone: _____ E-Mail: _____

Is it okay to contact you at home? ☐ yes ☐ no

**Is it okay to leave a (phone or text) message? ☐ yes ☐ no

Special instructions? _____

Your confidentiality cannot be ensured/guaranteed with unsecured phone and text messages. You are waiving your HIPPA guaranteed privacy by agreeing "yes" to receive or send text or phone messages. Please do not text the counselor with specific information you would like to keep confidential.

Religious affiliation: _____
Highest Grade or Degree Completed: _____
Marital/relationship status (Check one):

☐ Married ☐ Live with partner ☐ Single ☐ Separated/Divorced ☐ Widowed ☐ Other: _____

Employment status (Check all that apply):

☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Homemaker ☐ Unemployed

Current employer is: _____ Type of work: _____
Years on current job: _____ Business Phone: _____ Is it okay to contact you at work? ☐ yes ☐ no **Is it okay to leave a message? ☐ yes ☐ no Special calling instructions? _____

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EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to Client: _____
Address: _____
City _____ State _____ Zip Code _____
Home Telephone: _____ Other Phone (specify type): _____
**Is it okay to leave a (phone or text) message? ☐ yes ☐ no
Special calling instructions? _____

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are experiencing.

_____
_____
_____
_____

What has happened to cause you to seek help now? _____

_____
_____
_____

What do you hope to be able to do or achieve as a result of counseling?

_____
_____
_____

What do you consider to be other stresses in your life?

_____
_____
_____

CURRENT DIAGNOSIS

Diagnosis	Diagnosed by	Date	Describe any symptoms

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HISTORY OF THE PROBLEM

Approximately, when did you first start experiencing the problem(s) or concerns that brought you to the office today? _____
How often does the problem or concern occur? _____
How long does it last? _____

Do you have any thoughts of harming yourself? ☐ No ☐ Yes
If yes, please explain:_____

Have you ever attempted to harm yourself? ☐ No ☐ Yes
If yes, please explain:_____

Do you currently have any thoughts of harming someone else? ☐ No ☐ Yes
If yes, please explain:_____

Have you ever attempted to harm someone else? ☐ No ☐ Yes
If yes, please explain: _____

Have you ever had previous therapy/counseling of any kind? ☐ No ☐ Yes
If yes, when and for how long? _____
What concerns were addressed in therapy?_____
_____
Was this experience helpful (please explain)? _____
_____

Have you ever been hospitalized for emotional/behavioral problems? ☐ No ☐ Yes If yes, when/where was this:_____

Have you been prescribed medications to control emotional/behavioral/physical problems? ☐ No ☐ Yes
If yes, please list medications, when prescribed, and by whom: _____
_____
_____

Have you ever abused or experience (relational or legal) problems related to your use of drugs/alcohol?
☐ No ☐ Yes If yes, please explain:_____

Are you concerned that you have or maybe developing a problem with drugs/alcohol? ☐ No ☐ Yes If yes, please explain: _____
_____
_____
_____

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FAMILY BACKGROUND

Have you experienced a separation, divorces, or death in your immediate or extended family? ☐No ☐Yes
If yes, when? _____? Do you need help coping with this loss?____
Please describe the circumstances.
_____
_____
_____

As an adult or child have you experienced any issues related to physical/sexual abuse, inadequate nutrition, neglect, etc.) If Yes, describe:_____
_____

Please list the details of your extended family members (including those deceased, step, & half siblings):

Name	Age	Gender	Lives with client	Living	Relationship	Relationship Quality with client
		☐F ☐M	☐yes ☐no	☐deceased		☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased		☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased		☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased		☐poor ☐average ☐good ☐great
		☐F ☐M	☐yes ☐no	☐deceased		☐poor ☐average ☐good ☐great

Please list the details of your immediate family members (spouse & children,) who live in your household.

Name	Age	Gender	Relation to the client	Relationship Quality with client
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great
		☐F ☐M		☐poor ☐average ☐good ☐great

Has anyone in your family had treatment for emotional problems? ☐ No ☐ Yes
If yes, please briefly explain (who/when):_____

Has anyone in your family ever attempted or committed suicide? ☐ No ☐ Yes
If yes, please briefly explain (who/when): _____

Has anyone in your family had treatment for issues with drugs/alcohol? ☐ No ☐ Yes
If yes, please briefly explain (who/when):_____

CULTURAL/ETHNIC BACKGROUND

To which cultural or ethnic group, if any, do you belong?_____
Are you experiencing any problems due to cultural or ethnic issues? ☐ No ☐ Yes
If yes, describe:_____

Other cultural/ethnic information: _____

SPIRITUAL/RELIGIOUS CONSIDERATIONS

How important are spiritual matters to you? Not Little Moderate Much
Are you affiliated with a spiritual or religious group? ☐No ☐ Yes
If yes, describe:_____
Is your family affiliated with a spiritual or religious group? ☐No ☐ Yes
If yes, describe:_____
Would you like your spiritual/religious beliefs incorporated into counseling? ☐No ☐ Yes
If yes, describe: _____

FAMILY HEALTH INFORMATION

Describe your father's present health: _____

_____

Describe your mother's present health: _____

_____

Describe your siblings' present health:
_____

_____

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FAMILY HEALTH INFORMATION (continued)

Have any family members had any of the following (PLEASE CHECK IF YES)?
If yes, please specify family member's relationship to you.

	Relationship to you		Relationship to you
☐ Cancer		☐ Severe head injury	
☐ Tourette's syndrome		☐ Cerebral palsy	
☐ Diabetes		☐ Food allergies	
☐ Heart disease		☐ Alcohol/drug abuse	
☐ High blood pressure		☐ Nervousness	
☐ Behavior disorder		☐ Migraine headaches	
☐ Depression		☐ Multiple sclerosis	
☐ Mental Illness		☐ Physical disability	
☐ Mental retardation		☐ Stroke	
☐ Seizures/epilepsy		☐ Alzheimer's disease	
☐ Reading problem		☐ Other Learning Problem	
☐ Speech/language problem		☐ Sickle cell anemia	
☐ Sleep Difficulties		☐ Tics	
☐ Anxiety		☐ Bipolar Disorder	
☐ Attention Deficit/Hyperactivity Disorder			
☐ Other significant health or emotional problem			

What kinds of stressful events have you experienced recently? _____
_____
_____

What kinds of stressful events have family members experienced recently? _____
_____
_____

CLIENT MEDICAL HISTORY

Client's physician: _____ Telephone:_____
Address:_____

How often do you see a doctor? _____ Date of last visit: _____

Do you have any history of the following *(please check all that apply)*:

☐Abortion ☐Hay-fever ☐Pneumonia ☐Asthma

☐ Head injuries ☐Polio ☐Blackouts ☐Heart trouble

☐Pregnancy ☐Bronchitis ☐Hepatitis ☐Rheumatic Fever

☐Cerebral Palsy ☐Hives ☐Scarlet Fever ☐Chicken Pox

☐Influenza ☐Seizures ☐Congenital problems ☐Lead poisoning

☐Severe colds ☐Croup ☐Measles ☐Severe head injury

☐Diabetes ☐Meningitis ☐Sexually transmitted disease ☐Diphtheria

☐Miscarriage ☐Thyroid disorders ☐Dizziness ☐Multiple sclerosis

☐Vision problems ☐Ear aches ☐Mumps ☐Wearing glasses

☐Ear infections ☐Muscular Dystrophy ☐Whooping cough

☐Eczema ☐Nose bleeds ☐Encephalitis ☐Other skin rashes

☐Fevers ☐Paralysis ☐Other_____

List any current health concerns: _____

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions.

Condition/hospitalization	Age	Treated by whom?	Outcome of treatment

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CLIENT MEDICAL HISTORY (continued)

List any recent health or physical changes: _____

Please *check* if there have been any recent changes in the following: ☐Sleep patterns ☐Eating patterns ☐Behavior ☐Energy level ☐General disposition ☐Weight ☐Nervousness/tension ☐Physical activity level
Describe changes in areas in which you checked above: _____

EXAMINATIONS *(Please list all that apply below)*

Examination Type	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last vision exam			
Last hearing exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

MEDICATIONS

Current prescribed medications	Dose	Dates	Purpose	Noted Side effects

Allergic to any medications or drugs? ☐ No ☐ Yes If Yes, please describe._____

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NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____/ week		☐None ☐Small ☐ Med ☐Large
Lunch	____/ week		☐None ☐Small ☐ Med ☐Large
Dinner	____/ week		☐None ☐Small ☐ Med ☐Large
Snacks	____/ week		☐None ☐Small ☐ Med ☐Large

How often do you exercise? _____
What activities? _____

INTERESTS AND ACTIVITIES

Are you involved in any extracurricular activities, such as sports or music programs, clubs or religious organizations? ☐ No ☐ Yes If yes, please describe. _____
_____
_____
Please describe your strengths and positive characteristics. _____
_____
_____
Other information you feel is important and wasn't asked about._____
_____
_____

Thank you for your time and cooperation,

Luke T Morrissey Ed.S.
Licensed Professional Counselor

FOR COUNSELOR'S USE:

Counselor's Comments:
_____
_____
_____
_____

Physical exam: ☐ required ☐ not required at this time