Aspiring Hearts Counseling, PLLC
Mending Hearts... Changing Lives.

Adult Intake Questionnaire

Name:			Date:
Birth Date:	Age:	Soc Sec Num:	
Address:			
Home Phone:		Ok to leave messages? ☐ Yes ☐ No	
Cell Phone:		Ok to leave messages? ☐ Yes ☐ No	
Work Phone:		Ok to leave messages? ☐ Yes ☐ No	
Email:			

Reasons for Services/Symptoms (Check all that apply)

☐ Depression / Sadness	☐ Anger / Rage	☐ Anxiety / Worry	☐ Career Counseling	☐ Poor Memory
☐ Suicidal Thoughts	☐ Excessive Guilt	☐ Panic Attacks	☐ Crying Spells	☐ Fears / Phobias
☐ Suicidal Attempt(s)	☐ Addictive Behaviors	☐ Mood Swings	☐ Poor Concentration	☐ Sleeping Too Much
☐ Withdrawal/Isolation	☐ Sleeping Problems	☐ Sexual Issues	☐ Change in Appetite	☐ Low Energy
☐ Mania / Happiness	☐ Feeling Stressed	☐ Reckless	☐ Excessive Spending	☐ Unreasonable Avoidance
☐ Nightmares	☐ Confusion	☐ Paranoia	☐ Overwhelmed	☐ Repetitive Behaviors
☐ Hyperactive	☐ Grief / Loss	☐ Hallucinations	☐ Homicidal Thoughts	☐ Obsessive Thoughts
☐ Sleep Problems	☐ Uncaring Attitude	☐ Loss of Interest	☐ Bowel Movement Change	☐ Dangerous Behaviors
☐ Shortness of Breath	☐ Heart Palpitations	☐ Muscle Tension	☐ Obsessions/Compulsions	☐ Irritable
☐ Others:				

What stressors or problems do you have? (Check all that apply)

☐ Relationship Issues	☐ Family Problems	☐ Divorce	☐ Parenting
☐ Difficulty Coping	☐ Social Problems	☐ Recent Death, Loss, or Change	☐ Financial Problems
☐ Difficulty with Children	☐ Job/Work Problems	☐ Home/Housing Problems	☐ Health Problems
☐ Educational/School Problems	☐ Friend Problems	☐ Transportation Problems	☐ Self-Esteem Issues
☐ Others:			

Have you ever been arrested or been involved in a significant legal situation? ☐ Yes ☐ No (If No continue to next section)		
Number of Arrests:	Do you have pending charges? ☐ Yes ☐ No	Are you currently on probation or parole? ☐ Yes ☐ No
Charges and dates/ Significant legal situations and dates		

16 W. Martin St., Suite 401 ♥ Raleigh, NC 27601 ♥ 919-538-3458 ♥ Fax: 1-888-325-6160 ♥ info@aspiringhearts.com
www.aspiringhearts.com

Have you experienced anything traumatic? (check all that apply) ☐ None

☐ Physical Abuse ☐ Sexual Abuse ☐ Rape ☐ Domestic Violence ☐ Traumatic Injury

☐ Traumatic Accident ☐ Assault ☐ Robbery ☐ Death or Loss ☐ Witnessed Trauma

☐ Other:

Do you use tobacco? ☐ Currently ☐ Past ☐ None | Do you drink alcohol? ☐ Often ☐ Regularly ☐ Sometimes ☐ Rarely ☐ No

Do you use non-prescribed drugs? ☐ Regularly ☐ Socially ☐ Occasionally ☐ Rarely ☐ Never ☐ Past Use

Have you received mental health treatment in the past? ☐ Yes ☐ No | Have you been a patient of a mental hospital within the past year? ☐ Yes ☐ No

If Yes, what agencies?

Do you have a psychiatrist? ☐ Yes ☐ No Name/Agency:

Physician Name/Agency: | Phone:

Date of last physical: | Allergies:

Medical Problems:

Do you take any prescription or regular over the counter medications? ☐ Yes ☐ No (If yes, list below)

Medication	Dosage	Frequency	Reason for Medication

Medication concerns / Notable side effects:

Highest level of education completed:

☐ Some High School ☐ High School Diploma ☐ GED ☐ Some College/Tech School ☐ Diploma or Certification program

☐ Associates Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ All But Dissertation ☐ Doctorate ☐ Other

If you attended post-secondary school or obtained a diploma or certification, what was/were your major(s) or area(s) you reached your achievement(s):

Are you currently in school? ☐ Yes ☐ No If yes, What school:

What is your employment status:

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Not Working by Choice ☐ Disabled ☐ Retired

Are you seeking a new job or new career? ☐ Yes ☐ No ☐ Unsure | Military Status? ☐ None ☐ Active Duty ☐ Veteran

What is your current or last job/position:

Relationship status:

☐ Single ☐ Married ☐ Domestic Partnership ☐ Engaged ☐ Divorced ☐ Widowed ☐ Dating ☐ Other

Relationship History: (Check all that apply)

☐ Divorced and Remarried ☐ Multiple Divorces ☐ Death of Spouse/Significant Other

☐ Difficulty Finding Relationships ☐ Difficulty Maintaining Relationships ☐ Bi-sexual/Same Sex Relationships

☐ Current Domestic Violence ☐ Past Domestic Violence ☐ No Significant Relationships

Name of Current or Last Spouse/Significant Other: | Length of Relationship:

How would describe your current or last relationship?

☐ Great ☐ Good ☐ Fair ☐ Strained ☐ A lot of fighting/arguing ☐ Loving ☐ Controlling ☐ Abusive ☐ I want to end it

If you have children, please list their names and ages:

How would you describe your current family situation: (Check all that apply)

☐ No Problems ☐ Typical minor family problems ☐ Regular Family Fighting

☐ No Family ☐ CPS Involvement ☐ Estranged from some Family Members

☐ Single Parent ☐ Partial Custody of Children ☐ Lost Custody of Children

☐ Difficulty with Children ☐ Family has Limited Time Together ☐ Other

What is your Mother's Name:

How would you describe your relationship with your mother?

☐ Very Close ☐ Great ☐ Good ☐ Up and Down ☐ Tense ☐ Poor ☐ Abusive ☐ No Contact ☐ Mother Deceased

What is your Father's Name:

How would you describe your relationship with your father?

☐ Very Close ☐ Great ☐ Good ☐ Up and Down ☐ Tense ☐ Poor ☐ Abusive ☐ No Contact ☐ Father Deceased

How many Brothers do you have? | How many Sisters do you have?

How would you describe your relationship with your brothers and sisters?

☐ Close with All ☐ Close with Some ☐ Good ☐ Up and Down ☐ Tense ☐ Little Contact ☐ No Contact ☐ Some Deceased

Describe your childhood: (Check all that apply)

☐ Great Childhood ☐ Typical Childhood ☐ Poor Childhood

☐ Raised by Both Parents ☐ Raised by Mother ☐ Raised by Father

☐ Split Custody between Parents ☐ Raised by Another Family Member ☐ Adopted

☐ Foster Care ☐ Abused ☐ Close Family

☐ Low Socioeconomic Class Family ☐ Middle Class Family ☐ Upper Class Family

Are you aware of any developmental problems in your childhood or did your mother have any pregnancy or delivery complications?

☐ Pregnancy Complications ☐ Delivery Complications ☐ Speech Delay ☐ Walking Delay ☐ Motor Delay

☐ Psychological Delay ☐ Other Delay ☐ No Known Complications or Delays ☐ Unknown

Is there any Biological Family History of Mental Health Problems or Substance Abuse?

☐ No Family History of Mental Health or Substance Abuse ☐ Unknown Family History

☐ History of Mental Health Problems on Mother's Side ☐ History of Mental Health Problems on Father's Side

☐ History of Alcoholism on Mother's Side ☐ History of Alcoholism on Father's Side

☐ History of Drug Usage on Mother's Side ☐ History of Drug Usage on Father's Side

To which cultural or ethnic group, if any, do you belong?

Is there any cultural or ethnic info we should be aware of?

How religious or spiritual are you? ☐ A lot ☐ Moderately ☐ A Little ☐ Not at All

Which religious/spiritual group, if any, do you belong?

Describe your social life: (Check all that apply)

☐ I am very social ☐ I am moderately social ☐ I prefer to not be social

☐ I have a lot of friends ☐ I have a few close friends ☐ I have very little or no friends

☐ I have trouble making friends ☐ I would like to make more friends ☐ I am not a people person

☐ I used to be social but now not as much ☐ I get out a lot ☐ I would like to get out more

☐ I avoid crowds ☐ I avoid social situations ☐ Other

What are your hobbies, or things you like to do:

What are your strengths, or things you are good at:

What do you like about yourself or are proud of yourself for:

Emergency Contact:	Relationship:
Cell Phone:	Phone:
Address:	

Initial: I give Aspiring Hearts Counseling permission to contact the above listed Emergency Contact in the event of an emergency.

_____ I understand Aspiring Hearts Counseling may have to release confidential information to the Emergency Contact.

Signature:	Date: