

**CHRISTIAN WELLNESS CENTER
ADULT HISTORY/INTAKE FORM**

CLIENT INFORMATION

Name: _____

Address: _____

Date of Birth: _____ Social Security: _____

Gender: Male Female

Marital Status: Never Married Married Widowed

Divorced Separated Cohabiting

Phone (Home) # _____ Mobile: _____

Phone (Work) # _____ Ext. _____

Email : _____

Can we contact you at home? Yes No Can we contact you at work? Yes No

SOCIAL/FAMILY HISTORY

List all individuals currently living in your household:

Name _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Name: _____ Age: _____ Relationship to Client: _____

Insurance Information:

Insurance Company/HMO: _____ Phone: _____

Member ID# _____ Managed Care Company _____

Claims Address: _____ Phone: _____

Who is responsible for this account? _____

Relationship to client: _____ Employer: _____

Policyholder's Date of Birth: _____ Social Security: _____

Emergency Information

Primary Care Physician: _____ Phone: _____

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

PRESENTING COMPLAINT

(Please list below the main problems you are having at this time. You will be asked to give a more detailed description, in person at the initial interview)

What made you decide to come for treatment at this time?

Circle any of the following which apply to you **presently**:

Always tired	Poor appetite	Trouble getting to sleep
Waking up during the night	Lack of energy	Crying spells
Unable to have fun	Depressed	Can't concentrate
Can't get going	Loss of sexual interest	Can't make decisions
Lacking in motivation	Thoughts of hurting myself	Feeling worthless
Loss of meaning to life	Lacking in confidence	Unresolved grief
Feelings of guilt	Avoid contact with friends	Feeling inferior
Not enjoying usual activities	Feeling easily hurt	Tendency to put off doing things
Don't feel like being alone	Losing weight	Sleep whenever I can
Frequent thoughts about death	Loneliness	Troubled by childhood events
Nightmares	Reliving past events	Feeling fearful
Quick to startle	Unable to relax	Feeling irritable/on edge
Angry outbursts	Restless, tense	Fast heartbeat
Feeling panicky	Frequent sweating	Shaky hands
Dizzy, lightheaded	Nausea, stomach problems	Trouble swallowing
Numbness or tingling	Chills or hot flashes	Cold feet & hands
Constipation	Muscles twitching	Fainting spells
Headaches	Poor circulation	Poor health
Sexual problems	Always worried	Avoiding crowds
Unusual fears	Shy with people	Racing thoughts
Frequently daydreaming	Worried about health	Impatient with people
Feeling angry	Quick tempered	Feel like hurting someone
Feel like smashing things	Can't make friends	Can't handle money
Difficulties at work	Difficulties with school (past or present)	Full of energy
Financial problems	Unable to keep a job	Excessive drinking
Marital problems	Excessive use of drugs	Problems with children
Problems with parents	Excessive use of medication	Unable to pray
Feel distant from God	Unable to experience God's love and forgiveness	Confused about God

PREVIOUS MEDICAL HISTORY

Allergies (adverse reactions to medications/ food/ etc.)

Date of Last Physical Exam: _____

Findings from Exam:

Current Medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication): _____

Hospitalization/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc): _____

Any relevant medical conditions: (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.) _____

Past Psychiatric History (Mental Health and Chemical Dependency): _____

Prior Outpatient Therapy (Include previous practitioners, dates of treatment, previous treatment interventions, response to treatment interventions (including response to medications)

Results of recent lab tests and consultation reports: _____

Family Mental Health or Chemical dependency History:

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others					

Any other comments

