

**The Attachment and Trauma Center of Nebraska
Adult Psycho-social Intake Form**

Name _____ Therapist _____ Date _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

Please complete this psycho-social history form as fully as possible.

FAMILY OF ORIGIN

Parents' Names: _____

Were your natural parents married? Yes No. Are your natural parents still married? Yes No

If divorced, what year? _____

Siblings' names and ages: _____

Where number are you in the birth order? _____

If you were not raised by your birth parents, who raised you? _____

Has anyone in your immediate family died? Yes No

If yes, who? When? _____

Does anyone in your family have any mental health issues or problems with drugs/alcohol or other addictive substance or behavior? Yes No

If yes, who? When? _____

Other issues of importance? _____

How would you describe the relationship that your parents/guardians have with each other?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

How would you describe the relationship between you and your mother?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

How would you describe the relationship between you and your father?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

NUCLEAR FAMILY

Marital status: Single Married Partnered Separated Divorced

Name of Spouse/Partner: _____ Age: _____

Date of your present marriage/partnership: _____

Date(s) of any previous marriages: _____

Date(s) of any previous divorces: _____

Names of individuals living in your home:

Name	Age	Relationship to you
------	-----	---------------------

Name	Age	Relationship to you
------	-----	---------------------

Name	Age	Relationship to you
------	-----	---------------------

Name	Age	Relationship to you
------	-----	---------------------

Name	Age	Relationship to you
------	-----	---------------------

How would you describe your relationship between you and your spouse/partner?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

If a parent, how would you describe the relationship between you and your children?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

If you are single, how would you describe the relationship between you and most of your past partners?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

If applicable, how would you describe the relationship between you and your in-laws?

- Cold – distant Stormy – argumentative Loving – close
 Tolerant – put up with each other Abusive – verbal and/or physical fights

SCHOOL, WORK & FINANCIAL

Highest level of education completed? _____

If you graduated from college, what is your area of study? _____

What kinds of grades did you usually make (High School & beyond)? _____

Please list schools attended beyond high schools: _____

What is your present job? _____

How long have you had this job? _____

How do you feel about your work? Hate it Tolerate it Enjoy it

What future job or profession do you hope to have? _____

How would you describe your present financial condition? Very bad Fair Good Excellent

SPIRITUAL/COMMUNITY INVOLVEMENT, HEALTH & ABUSE

Do you have spiritual or religious beliefs which you draw on? Yes No

How do you honor or attend to these beliefs? _____

Do you participate in any community activities or organizations? Yes No

If Yes, please list: _____

Do you consider yourself to be in Excellent Health Good Health Fair Health Poor Health

Have you ever been in the hospital? Yes No If Yes, explain: _____

Please list medications and doses currently taking: _____

Have you ever seen a therapist (Psychiatrist, Psychologist, Counselor, Social Worker)? Yes No

If yes, when? _____ Reason for treatment: _____

If yes, what was helpful about the therapy? _____

Check any of the following you have experienced:

Verbal Abuse. By whom? _____

Physical Abuse. By whom? _____

Sexual Harassment. By whom? _____

Sexual Abuse. By whom? _____

Rape. By whom? _____

SUBSTANCE ABUSE: Check all the following that apply to you:

Have you ever felt you ought to cut down on your drinking or drug use?

Have people annoyed you by being critical about your drinking or drug use?

Have you ever felt bad or guilty about your drinking or drug use?

Have you ever had a drink or drug first thing in the morning to steady your nerves or get over a hangover?

Re-read the 4 questions above and consider the following:

Shopping – Have you or others in your life been concerned about your shopping? Yes No

Gambling - Have you or others in your life been concerned about your gambling? Yes No

Eating - Have you or others in your life been concerned about your eating? Yes No

Sexual behavior - Have you or others in your life been concerned about your sexual behavior? Yes No

Internet usage - Have you or others in your life been concerned about your Internet usage? Yes No

Other addictive behavior, you may be concerned about? _____

Are any of the following conditions a concern or problem to you at this time?

(Check all that apply)

- Anxiety
- Grief
- Depression
- Irrational fears
- Nervousness
- Loneliness
- Anger
- Parenting
- Marriage problems
- Sexual concerns
- Loss of work/job

- Self esteem
- Stress
- Substance abuse
- Binge eating
- Chronic fear
- Guilt feelings
- Suicidal feelings
- Loss of hope
- Rage
- Trauma
- Domestic Violence

- Relationship with parents
- Relationship with children
- Relationship with partner
- Loss of meaning in life
- Legal concerns
- Conflicts at work
- Life/Career Planning
- Other (list)

If any of these statements are true, check the box.

- I have thoughts of harming myself or others.
- Thoughts of harming myself or others is a frequent occurrence.
- I dwell on these thoughts and wonder if I can control them.
- I Have sought professional help because of these thoughts or feelings.

What are your greatest strengths? _____

Other information that we should know as we start counseling? _____

What would you like to see happen as a result of psychotherapy or counseling? _____

Thank you for taking the time to complete this form.