Adult Background Information

SMU Center for Family Counseling

6116 N. Central Expressway, Suite 410, Dallas, TX 75206
214-768-6789
www.smu.edu/familycounseling

Welcome to the Center for Family Counseling at SMU! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your intake counselor will discuss your responses with you after he/she has reviewed the form.

Name: _____ *First Visit Date:* _____
Last First MI
Gender Identification: Male__ Female__ Other: _____
*Date of Birth*_____ *Age*_____

Occupation: _____ *Length of Time at this Job:*_____

Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other_____

Primary language: English ___ Spanish ___ Other ___

CONTACT INFORMATION:

Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Best Time and Place to call:_____
Mailing Address:_____
Street City State Zip
May we correspond with you via mail at the above address: Yes No

In case of emergency, I authorize the Center for Family Counseling to contact:

_____
Name: Last, First Relationship Phone

Person responsible for financial arrangements with our clinic: _____
Name: Last, First
Who referred you to our Center? (Please be specific): _____

May we contact this referral source to thank them for the referral: Yes No

CURRENT CONCERNS

General reason(s) for seeking counseling services at this time:

_____

_____

_____

*Circle all items that you see as ongoing struggles in your life that you would like to work on in counseling

Issues Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment/rejection
Suspected sexual abuse
History of family domestic violence

Mood-Related Concerns
Disturbing memories
Difficulty going to sleep/Staying asleep
Nightmares/Night terrors
Suicidal thinking or talking
Suicidal attempting
Sadness/Depression
Feelings of guilt and shame
Excessive worrying or fear

Behavioral/Conduct Issues
Aggression toward others
Drug/alcohol use
Hyperactive/Impulsivity
Excessive computer use
Lying
Betraying relationships
Engaging in high risk-taking behaviors
Fire-setting
Other unusual behaviors (please specify) _____

Career/Academic Issues
Colleague/Cohort problems
Harassment issues
General work performance issues
Failing grades
Chronic stress
Career dissatisfaction
General problems at work/school

Family Relationship Concerns
Difficulty adjusting to family changes
Parenting/Discipline concerns
Parent-child relationship problems
Divorce
Separation
Religious/Spiritual Concerns
Estranged relationships
Constant fighting

Other Behavioral Concerns
Sexual identity questioning
Sexual issues in general
Appetite/Eating concerns
Sleep problems
Time management concerns
Inattentive
Lonely
Bored with Life

****Please place a star by the most significant issue***

When did you first become concerned about the main/most significant issue?_____

Other treatment you have received to address any of the concerns indicated above: None____
Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____

Are you currently in counseling elsewhere? Yes No
(If yes, we require written confirmation of the counselor's consent for treatment by the center)

Are other family members receiving services at this clinic? Yes No
(Name/Dates of service)_____

Are you seeking services because you are a victim of a crime? Yes No

If yes, did it result in legal action? Yes No *Are you currently on probation?* Yes No

Have you ever been dishonorably discharged from the military? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If yes, we will need your permission in order to communicate with that individual or agency. We reserve the right to postpone services until prior treatment providers are contacted.)

Previous Mental Health Professional/Agency_____
Name Address
Phone_____ Dates of Service_____(beginning - ending)

Check the following items for a diagnosis or medication you are now receiving or have received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Learning disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If you have been diagnosed, who gave the diagnosis?
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___
Other_____
Name: _____ Phone #: _____

List other medication you are currently taking:
Med._____ Dosage_____
Med._____ Dosage_____
Med._____ Dosage_____

History of family violence: Yes No
*(If yes, please explain)*_____

History of criminal activity: Yes No
(If yes, please explain) _____

History of Protective orders: Yes No
(If yes, please explain) _____

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.

_____

Client/Guardian Date