

# Rob Reinhardt, LPC, PA

Adult & Adolescent Intake Interview

Web [www.robreinhardtllpc.com](http://www.robreinhardtllpc.com)

Phone 919.414.7712

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## CLIENT INFORMATION

First Name <input type="text"/>	Middle <input type="text"/>	Last <input type="text"/>	Date Completed (MM/DD/YYYY) <input type="text"/>
Gender <input type="text"/>	Date of Birth (MM/DD/YYYY) <input type="text"/>		
How Were You Referred? <input type="checkbox"/> Google Search <input type="checkbox"/> Psychology Today <input type="checkbox"/> Other Professional		Referrer's Name <input type="text"/>	Other Referrer <input type="text"/>
Completed By (If Not Client) <input type="text"/>	Phone <input type="text"/>	Relationship <input type="text"/>	
Primary Reason For Appointment <input type="text"/>			

## PERSONAL HISTORY

Following are questions regarding your personal history. The purpose of this form is to gather initial background information in order to save time in your first session. Please feel free to skip questions that do not apply to your particular situation or that you are not comfortable answering. Please note that the more information you share, the more complete picture your counselor will have of your situation. You will have an opportunity in your first session to provide more details and ask questions about this form.

Have you ever attended Counseling/Therapy Before?  Yes  No If so, with whom?

Details (When, How Long, etc.):

Are you a current patient of a Psychiatrist?  Yes  No If so, Who?

Have you ever attempted suicide or had a plan to harm yourself?  Yes  No If so, When?

Details:

Do you currently have any thoughts and/or feelings of wanting to physically harm yourself?  Yes  No

If so, please explain:

Have you, in the past, or are you currently under treatment for substance abuse?  Past  Current  N/A

If so, please explain:

Are you a survivor of any of the following forms of abuse?  Emotional  Physical  Sexual  None

If so, please explain:

Have you ever received a formal diagnosis from a mental health professional?  Yes  No

If so, please explain:

Is there any history of mental disorders/illness in your family?  Yes  No

If so, please explain:

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## MEDICATIONS (Please note medications you are currently taking)

Medication	Dose	Start Date	Who Prescribes?	Purpose

Is there anything else we should know about your medication(s) (i.e. other prescriptions, supplements, side effects, etc.)

## RELATIONSHIPS (Please note any significant family members, relationship partners, friends, etc.)

First Name	Relationship	Age	Live With?	Notes
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	
			<input type="checkbox"/> Yes	

How do you typically relate to other people (Check all that apply):

Affectionate  Aggressive  Avoidant  Fight/Argue Often  Follower  Friendly  Leader

Outgoing  Shy/Withdrawn  Submissive

Other (Please Explain)

## EDUCATION

Please check any of the following that apply:

High School Grad/GED  Vocational School  College  Grad School  Other

Please note any other significant educational information (degrees obtained, learning disabilities, special trainings, current plans, etc.)

## EMPLOYMENT

Please check any that apply:  Part-Time  Full-Time  Contractor  Self-Employed  Stay At Home Parent  Retired

Employer:

Position:

How Long?

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## CULTURE/ETHNICITY

With which cultural or ethnic group(s), if any, do you identify?

Please describe any issues/challenges you are experiencing due to cultural or ethnic issues:

## SPIRITUALITY/RELIGION

How important to you are spiritual/religious matters?  Not  Minor  Moderately  Very

Are you affiliated with a spiritual/religious group?  Yes  No If Yes, describe:

Were you raised in a spiritual/religious group?  Yes  No If Yes, describe:

Please share any other important thoughts/notes about spirituality/religion you feel it important that your counselor understand:

## LEGAL

Are you involved in any active legal cases (traffic, civil, criminal)?  Yes  No

If so, please explain:

Are you presently on probation or parole?  Yes  No

If so, please explain:

Please share any other important current or past legal history you feel it is important that your counselor be aware of:

## LEISURE/RECREATION

Please describe any leisure/recreational/hobby activities that you engage in.

Activity	How Often Now?	How Often In the Past?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## NUTRITION

How would you rate the quality of your nutrition/diet/eating habits?

Poor  Could Use Improvement  Adequate  Above Average  Excellent

Please share any food/nutrition related thoughts/issues/challenges you feel your counselor should be aware of:

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## MEDICAL

How would you rate your current overall physical health?

- Poor  Could Use Improvement  Adequate  Above Average  Excellent

Please describe any current health concerns and/or recent changes in your health:

Please describe any family history of medical problems:

Please check if there have been any recent changes in the following:

- Sleep  Eating/Diet  Behavior  Energy Level  Physical Activity  General Mood  Weight  Stress

Please describe any changes you checked above:

Do you drink alcohol?  Yes  No If so, how often?

Do you smoke?  Yes  No If so, how often?

## SYMPTOM CHECKLIST

Please check any of the following that you feel apply to you (on a regular basis):

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Aggressive            | <input type="checkbox"/> Disturbing Thoughts | <input type="checkbox"/> Impulsive          | <input type="checkbox"/> Poor Concentration    |
| <input type="checkbox"/> Alcohol Dependency    | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Incompetent        | <input type="checkbox"/> Recurring Thoughts    |
| <input type="checkbox"/> Angry                 | <input type="checkbox"/> Drug Dependence     | <input type="checkbox"/> Inferior           | <input type="checkbox"/> Regrets for Past      |
| <input type="checkbox"/> Anti-Social           | <input type="checkbox"/> Elevated Mood       | <input type="checkbox"/> Internet Addictior | <input type="checkbox"/> Restless              |
| <input type="checkbox"/> Anxious               | <input type="checkbox"/> Empty Feelings      | <input type="checkbox"/> Irritable          | <input type="checkbox"/> Sexual Addiction      |
| <input type="checkbox"/> Avoid People          | <input type="checkbox"/> Evil                | <input type="checkbox"/> Judgement Errors   | <input type="checkbox"/> Sexual Difficulties   |
| <input type="checkbox"/> Bad Home Environment  | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Lonely             | <input type="checkbox"/> Sick Often            |
| <input type="checkbox"/> Bored                 | <input type="checkbox"/> Financial Problems  | <input type="checkbox"/> Memory Problems    | <input type="checkbox"/> Sleep Problems        |
| <input type="checkbox"/> Cannot Make Decisions | <input type="checkbox"/> Gambling Problem    | <input type="checkbox"/> Misunderstood      | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Confused              | <input type="checkbox"/> Guilty              | <input type="checkbox"/> Mood Swings        | <input type="checkbox"/> Thoughts of Self Harm |
| <input type="checkbox"/> Controlling           | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Nightmares         | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Depressed             | <input type="checkbox"/> Hateful             | <input type="checkbox"/> Not Confident      | <input type="checkbox"/> Unattractive          |
| <input type="checkbox"/> Disorganized Thoughts | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Not Loved          | <input type="checkbox"/> Withdrawing           |
| <input type="checkbox"/> Disorientation        | <input type="checkbox"/> Heart Palpitations  | <input type="checkbox"/> Panic Attacks      | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Distractible          | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Phobias/Fears      | <input type="checkbox"/> Worthless             |

Please list your strengths and positive influences in your life:

Please describe your goals for counseling / things you would like to change about your life: