**Martha R. Durham, PhD**

**Licensed Psychologist (SC # 981)**

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**Adult Intake Form**

**Chief Concern**

Please describe the main difficulty that has brought you to see me:

**Your medical care** (From whom or where do you get your medical care?)

**Clinic name:**

**Phone:**

**Doctor's name:**

**Address:**

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

**Your current employer**

**Employer:**

**Work phone:**

**Address:**

**Occupation:**

**Length of time with this employer:**

**Please indicate any restrictions on calls:**

**Present relationships**

How do you get along with your spouse or partner?

How do you get along with your children?

**Past Psychological/Psychiatric Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

**When:**

**From Whom:**

**For What:**

**Results:**

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

**When:**

**From Whom:**

**For What:**

**Results:**

**List of Symptoms**

Please circle any of the following that have been bothering you lately:

abused as child agoraphobia alcohol use

ambition anger anxiety

appetite being a parent bowel trouble

career choices children compulsions

compulsivity concentration confidence

depression divorce drug use/abuse

eating problem education energy (hi/low)

**Continued: List of Symptoms**

extreme fatigue fears fetishes

finances friends guilt

headaches health problems inferiority feelings

insomnia loneliness making decisions

marriage memory my thoughts

nervousness nightmares obsessive thinking

overweight painful thoughts panic attacks

phobias relationships sadness

self-esteem separation sexual problems

short temper shyness sleep

stress suicidal thoughts work

**Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:**

**Marriage / Relationship:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Family:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Job/school performance:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Friendships:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Financial situation:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Physical health:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Anxiety level / nerves:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Mood:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Eating habits:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Sleeping habits:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Sexual functioning:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Alcohol / drug use:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Ability to concentrate:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Ability to control anger:**

1 - No effect 2 – Little effect 3 – Some effect

4 – Much effect 5 – Significant effect Not Applicable

**Substance Use**

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

**Other**

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.