Anchor & Balance Restorative Services, LLC
Sarah B. Michalowski, DSW, LCSW
175 Fairfield Avenue – Suite 1C
West Caldwell, NJ 07006
551-333-9679 (google voice)

Adult Intake Form

Please provide the following information. Please note this information will be kept confidential

Demographic Information

Date: _____

Name: _____
(Last) (First)

DOB: _____ Age: _____ Gender: _____

Ethnicity: _____ Religious Background: _____

Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ *Is it ok to leave a voicemail?* *YES* *NO*

Cell Phone: _____ *Is it ok to leave a voicemail?* *YES* *NO*

Email: _____
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Referred by: _____
(Name) (Relationship)

Is it okay to send the referral source a "thank you"? *YES* *NO*

If Yes, Referral contact information:

_____
(Address) (Email) (Phone)

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How Have We Come to Meet?

What are the three biggest concerns or symptoms you are having right now for which you are seeking services (i.e., significant life changes, stressful events or losses, etc.)? How long have each been going on? Please list them in order of importance:

1. _____
2. _____
3. _____

What do you think those that care about you would say their concern(s) is/are in regards to you?

_____

What solutions (helpful or unhelpful) have you tried to resolve your concerns?

_____

Have you had therapy in the past? If so, please provide treatment providers names and dates of services. What reasons did you attend therapy for? Please share about your experience. What was helpful? What was not helpful?

Change is Coming…

What are your expectations/goals from therapy? What are your expectations of the therapist?

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you would like to see happen during the course of therapy:

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What other things would you like to see change in your life (family, career, health, relationships, etc.)?

_____
_____
_____
_____
_____
_____
_____

Do you foresee any obstacles to achieving your goals or the desired changes?

_____
_____
_____
_____
_____
_____
_____

How long do you think therapy will need to last to achieve your goals? Write down a target date:

_____

List 5 strengths about yourself or that others say about you, give examples of each:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

- CONTINUED ON NEXT PAGE -

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

_____
_____

Medical & Wellness Information

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)? Give examples:

_____
_____
_____

How do you achieve balance in your life?

_____
_____
_____

Have you ever received psychiatric services before (including hospitalizations)?
If yes, how long ago, with whom, for what, medications prescribed and results:

_____
_____
_____

Are you presently under a physician's/psychiatrist's care? If so, for what reason?

_____
_____
_____

Do you have any allergies (food, environmental, medicinal, animal, etc.)?

_____
_____
_____

Do you have any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, what?

_____
_____
_____

Is there a family history of the above medical issues/concerns?

_____
_____
_____

Is there anyone in your life that is currently dealing with a medical issue that you are concerned about? If so, whom, for what?

_____
_____
_____

In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

_____
_____
_____

Have you ever served in the military? If so, when?

_____
_____

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

_____
_____
_____

Important Questions I Must Ask

Have you ever had thoughts that you did not want to live? YES NO
If yes, please explain:

_____
_____

Do you currently feel that you do not want to live? YES NO
If yes, please explain (i.e. how often do you have the thought, when was the last time you had the thought, did something happen to make you have the thought, would anything make it better):

_____
_____
_____

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Have you ever had thoughts of killing yourself? YES NO
If yes, please explain (is the method readily available):

_____

_____

Have you ever planned on killing yourself? YES NO
If yes, please explain:

_____

_____

Have you ever attempted to kill yourself? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Have you ever felt you wanted to seriously harm or kill someone else? YES NO
If yes, please explain:

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Have you ever or are you currently engaging in self harm? YES NO
If yes, please explain (current or past and with what/how):

_____

_____

Is there any past or present abuse (sexual, physical, emotional, neglect) or violence? YES NO
If so, please explain (including DCP&P involvement):

_____

_____

_____

Have you ever witnessed or experienced a trauma? Do you have reoccurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

Do you have a history of substance abuse (alcohol or drugs)? If yes, please explain:

Are you currently using any illegal drugs or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

Are you concerned about hearing or seeing things that do not appear to be real? If so, please explain:

Do you have past or current legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

Career/Job, Recreation and Leisure

What is your current occupation? How would you describe your fulfillment of your job/career?

What is your highest level of education completed and field of study?

What do you enjoy doing during your free/leisure time?

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Intimate Relationships

If you are currently in a relationship, describe your relationship:

_____
_____
_____

How would you describe your communication?

_____
_____
_____

How would you describe intimacy and/or sex in your relationship?

_____

---

* If you are in a relationship answer the following regarding your relationship:

1. Like _____
2. Dislike _____
3. Not enough of _____
4. Too much of _____
5. Ideal relationship _____

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Understanding Your Family & Influences

** Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

Please describe your relationship with your parents:

_____
_____
_____

How would you describe your upbringing?

_____
_____
_____

Who do you currently live with?

_____
_____
_____

Do you have any pets? If yes, names, types and relationship to each pet:

_____
_____

Describe your relationship with each family member:

Mother:

_____

Father:

_____

Mother's Significant Other:

_____

Father's Significant Other:

_____

Siblings: Age, Name, Sex:

a. Sibling 1

_____

_____

b. Sibling 2

_____

_____

c. Sibling 3

_____

_____

Significant Other/Spouse:

_____

_____

Children: Age, Name and Sex:

a. Child 1

_____

_____

b. Child 2

_____

_____

c. Child 3

_____

_____

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Relationships

Describe your relationship with your friends:

_____
_____
_____

Who would you say your support system is (people, organizations, or affiliations)?

_____
_____
_____

Do you belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____
_____
_____

How do your religious or spiritual beliefs/practices influence your life?

_____
_____
_____

Please list anything else that is important for me to know about you that would assist me in working with you to achieve your desired results:

_____
_____
_____
_____
_____
_____
_____
_____
_____

- Thank You –

_____ _____
Clinician, Credentials Date

