Sharon Hahn Counseling, PLLC
Sharon Hahn, MS, LPC
5613 Duraleigh Rd. Suite 161
Raleigh, NC 27612

Office: (919) 784-0205 ext. 4
Email: sharonhahnlpc@gmail.com
Website: www.sharonhahn.com

Adult Intake Evaluation

Please fill out this intake evaluation completely. Your information will be held in strict confidence, according to confidentiality laws and statute.

Today's date: _______________

Current demographic information

Your full name: ____

Date of birth / Age: ____

Complete address: ____

____

Phone numbers: Home: __________________ Work: ____________________Cell: __________________

Email address: ____

Emergency contact person and phone number(s): ____

Please state who referred you to this office: ____

Presenting issues

Please briefly state why you are seeking professional counseling services at this time, and what you hope to change: ____

____

____

____

____

Symptom checklist: Please choose relevant symptoms with
(**F**) -- frequent; (**S**) -- sometimes; (**R**) -- rarely. Leave blank those that you do not experience at all.

Depressed mood		Feeling disoriented or dizzy	
Depressed mood with mixed periods of elevated and expansive mood ("highs and lows")		Physiological symptoms (heart palpitations, sweating, shortness of breath, trembling, nausea)	
Diminished interest in previously enjoyed activities		Excessive worrying without being able to stop	
Feelings of loneliness		Thoughts of suicide or wishing to be dead	
Significant weight loss		Panic or "anxiety attacks"	
Significant weight gain		Obsessions (not being able to get thoughts out of you mind)	
Insomnia (can't get to sleep)		Physically sick often	
Hypersomnia (over sleep)		Compulsions (feeling compelled to behave in a certain way without being able to stop)	
Memory impairment		Muscle tension and rigidity	
Difficulty maintaining sleep through night		Fear of losing control	
Nightmares		Hallucinations	
Fatigue or loss of energy		Phobias (fears of certain things or events)	
Diminished ability to concentrate and focus		Substance abuse or addiction	
Suspiciousness and paranoia		Problems related to sexual issues	
Avoiding people		Aggression, violent toward others	

Other:

____

____

Please state how long you have been having the above noted symptoms and give examples of how these symptoms interfere with your ability to function: ____________________________________

____

____

____

List your greatest strengths:

___

___

___

List your greatest weaknesses:

___

___

___

List your main social difficulties:

___

___

List your main love and sex difficulties:

___

___

List your main difficulties with work and/or school:

___

___

List your main difficulties at home:

___

___

___

___

Please list any additional information that would be helpful for me to better understand you:

___

___

___

___

___

____

____

Personal Information – Adult

Please state marital status (married/divorced/separated/single): ___________________________

Please note the number of children you have and their ages:

Have you suffered any miscarriages?______ If yes, how many?_____________
Have you had any abortions?_______ If yes how many?_____________

Please state all members who reside with you and their relationship to you: _______________________

____

____

Please note your highest level of education completed: _______________________________________

Please list your occupation: ____

If you are employed, please note your feelings about your job: _________________________________

____

____

Please note if you have a particular religious, cultural, or spiritual affiliation and, if so, if you would like your beliefs incorporated into the counseling process:

____

____

____

Please note if you have suffered any legal difficulties or penalties, other than minor traffic violations, as an adult *(this information will be held in strict confidence)*: ____________________________________

____

Please list hobbies or extracurricular interests you have: ______________________________________

____

____

____

Medical and psychological history

Please state your primary care physician: ____

Please state all current medical illnesses. List current medication taken and dosage if applicable.

____

____

____

Please state any past medical illnesses. List past medication and dosage if applicable.

____

____

____

Please state if you have been involved in counseling/psychotherapy previously, and. if so, state the reason and outcome of services received:

____

____

____

Please note any medical or mental health illness in your biological family (depression, bipolar disorder, substance abuse or addiction, violence/abuse, criminal activity, etc.) ______________________________

____

____

____

____

Childhood Information

Which of the following best describes the family you grew up in?

Warm and accepting ______ Average ______ Hostile and fighting

1 2 3 4 5 6 7 8 9

Which of the following best describes the way in which your family raised you?

Allowed me to be independent ______ Average ______ Attempted to control me

1 2 3 4 5 6 7 8 9

Please state what type of family you grew up in. (A traditional family with both biological parents, a divorced family with one parent, a blended family with step-parents and siblings, an adoptive family, etc.)

____

____

____

____

Briefly describe your mother (or mother figure) and your relationship with her: ____________________

____

____

____

Briefly describe your father (or father figure) and your relationship with him: ____________________

____

____

____

Briefly describe your relationships with siblings, if applicable: ________________________________

____

____

____

Please note any traumatic or unusual experiences you experienced growing up as a child: ___________

____

____

______________________________ ________________
Sharon Hahn, MS, LPC Date