CORNERSTONE OF HOPE
ADULT CLIENT INTAKE PAPERWORK

Demographic / Background Information

Date:

Name (First and Last)**:**

Address:

City/Zip:

Cell Phone: _____ **Home Phone:** _____
May we leave a message: □ Yes □No

Email:

Date of Birth/Age: Month_____ Day _____ Year _____ Age _____

Gender: **Social Security No:** _____ - _____ - _____

Race/Ethnicity:
□ African American/Black □Multiracial □Asian □ American Indian/Alaska Native □ Caucasian
□ Hawaiian Native/Pacific Islander □Hispanic □ Other: _____

Marital Status: □ Married □ Single □ Widowed □ Divorced
□ Living Together □ Partners □ Engaged □Separated

Religion/Spirituality: □ Atheist □Agnostic □ Buddhist □ Catholic □ Christian □ Hindu □ Jewish
□ Muslim □ None □Protestant □Other: _____

Referral Source: *(How or who referred you to Cornerstone of Hope?)*

Emergency Contact Information

Name (First and last)**:**

Relationship *(to you):*

Phone: Cell: _____ **Home:** _____ **Work:**_____

Immediate Family Members

Name	Relationship	Age

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Living Situation

Home □ Own □ Rent □ Other

□ Hospital □ Temporary Housing □ Residential Care □ Nursing Home □ Jail/Prison
□ Respite Care □ Foster Care □ Friend's Home □ Homeless in Shelter/No Residence
□ Homeless Living with Friend □ Relative's/Guardian's Home
□ Other_____

Current Loss

Name of loved one who died: *(First and last name)*	**Cause of death:**
Date of death:	**Age:**

The deceased was my: □ Spouse □ Significant Other □ Child □ Aunt □ Uncle □ Cousin
□ Sister □ Grandmother □ Mother □ Father □ Brother
□ Grandfather □ Other_____

Relationship with the deceased: □ Very Close □ Close □ Not very close □ Distant □ Estranged

The death was: □ Sudden □ Anticipated

Were you present at the time of death? □ Yes □ No

Was there a funeral/memorial service for your loved one?
□ Yes □ No □ Cremation □ Funeral Service □ Memorial □ Visitation □ Did not attend

Other Loss #2:

*Name and relationship:*_____

Date of death: _____

Cause of death: _____

Other Loss #3:

Name and relationship: _____

Date of death: _____

Cause of death: _____

Employment History

Employment Status: □ Full-Time Student □ Employed □ Retired
□ Part-Time Student □ Unemployed □ Disabled

Any changes of Employment since loss? □ Yes □ No
Explain changes:

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Communication Needs

Special Communication Needs

□ None □ Assistive Listening Device □ Sign Language Interpreter □ TDD/TTY Device □ Other: _____

□ Language Interpreter Services Needed/Other Spoken Language _____

Medical History

Physician Name and phone:

List any health issues (current and past)**:**

Medication Name	Dosage (mg/day)	Purpose	Effective?	Dates Taken	Prescribed By
			□ Yes □ No		
			□ Yes □ No		
			□ Yes □ No		

Therapy/Counseling History:

Have you ever been given a mental health diagnosis? □ Yes □ No

If yes, please specify:

Have you ever been in counseling before? □ Yes □ No

When (provide dates)**:**	**Agency Name:**
Reason for counseling:	
Are you currently in therapy or counseling? □ Yes □ No	**Permission to contact** □ Yes □ No
Counselor Name:	**Agency Name & Phone Number:**
Reason for counseling:	
Family Mental Health History:	

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Concurrent Stressors:

Grief Reactions:

- □ Anxiety
- □ Appetite Changes
- □ Depressed Mood
- □ Disorganized Thoughts
- □ Fatigue/Low Energy
- □ Feelings of Guilt
- □ Feelings of Panic
- □ Hopelessness
- □ Intense Crying
- □ Irritability/Anger
- □ Loneliness
- □ Loss of Pleasure in Hobbies
- □ Memory Impairments
- □ Physical Complaints
- □ Poor Concentration
- □ Recurring Thoughts/Images
- □ Sleeping Changes
- □ Social Isolation
- □ Substance Abuse
- □ Weight Changes
- □ Worthlessness
- □ Other _____

Personal/Relational:

- □ Anger/Difficulty Controlling Temper
- □ History of Abuse/Neglect
- □ Infidelity
- □ Lack of Emotional Support
- □ Medical Problems
- □ Other _____

Life Adjustment:

- □ Addition of Parent to House
- □ Being a Single Parent
- □ Divorce/Separation
- □ Employment Stress
- □ Financial Problems
- □ Loss of Household Income
- □ Moving to New Location
- □ Newly Married or Remarried
- □ Parenting a Newborn
- □ Stepfamily with Children
- □ Unemployment
- □ Other _____

Family:

- □ Children Having Difficulty with Divorce or Remarriage
- □ Custody or Visitation Problems
- □ Major Difficulties with Child or Teen
- □ Children Having Difficulty with Loss of Loved One
- □ One or More Family Members Not Getting Along
- □ Other _____

Please provide details to any of the checked items:

Availability for counseling: (Check all that apply) Please note that your preferred time slot is not guaranteed.

Monday: ___Morning ___Afternoon ___Evening

Tuesday ___Morning ___Afternoon ___Evening

Wednesday ___Morning ___Afternoon ___Evening

Thursday ___Morning ___Afternoon ___Evening

Friday ___Morning ___Afternoon ___Evening

Client Signature: _____ **Date**: _____