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**INTAKE FORM – Please complete to the best of your ability.**

Today's date: \_\_\_\_\_ Intake by: \_\_\_\_\_

\_\_\_\_ Would like 'one-to-one' peer counseling

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Ok to leave message? \_\_\_ yes \_\_\_ no

Email address: \_\_\_\_\_ Ok to be on email list? \_\_\_ yes \_\_\_ no

***Please know that call backs or messages will come from "Adam C." so you know we tried to reach you.***

**A. When can you come in?**

Please 'check' your availability below: (approximately 1 hour sessions beginning on the hours listed below)

Monday AM: \_\_\_\_\_ 6-7-8 PM: \_\_\_\_\_

Tuesday AM: \_\_\_\_\_ 6-7-8 PM: \_\_\_\_\_

Wednesday AM: \_\_\_\_\_ PM: blocked

Thursday AM: \_\_\_\_\_ PM: \_\_\_\_\_

Friday AM: \_\_\_\_\_ PM: \_\_\_\_\_

Saturday AM: \_\_\_\_\_ PM: \_\_\_\_\_

If there is another time or day not listed here (including Saturday) that would work better for you, please note it and your Volunteer Peer Counselor **may** be able to accommodate that need.

**B. Other helpful information:**

If employed, where? \_\_\_\_\_

\_\_\_ married \_\_\_ single \_\_\_ other: \_\_\_\_\_

\_\_\_ # of children \_\_\_ # living at home \_\_\_ # living elsewhere, please explain \_\_\_\_\_

Do you attend church? \_\_\_ never \_\_\_ rarely \_\_\_ sometimes \_\_\_ weekly

If yes, where? \_\_\_\_\_

How did you hear about the Adam Center? \_\_\_\_\_

**C. Have you ever been in counseling before? \_\_\_no \_\_\_yes, If yes, where, when and what for?**

\_\_\_\_\_

Are you in the care of a medical doctor? \_\_\_ no \_\_\_ yes For what concerns? \_\_\_\_\_

**Please check all issues that apply. This is part of your confidential record.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Rejection      | <input type="checkbox"/> Divorce            | <input type="checkbox"/> Parenting     |
| <input type="checkbox"/> Abuse-sexual   | <input type="checkbox"/> Eating issues      | <input type="checkbox"/> Pornography   |
| <input type="checkbox"/> Abuse-domestic | <input type="checkbox"/> Employment         | <input type="checkbox"/> Promiscuity   |
| <input type="checkbox"/> Aging          | <input type="checkbox"/> Fears/phobias      | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Aging parents  | <input type="checkbox"/> Finances           | <input type="checkbox"/> Self-esteem   |
| <input type="checkbox"/> Alcohol/drugs  | <input type="checkbox"/> Grief              | <input type="checkbox"/> Singleness    |
| <input type="checkbox"/> Anger          | <input type="checkbox"/> Wife/partner       | <input type="checkbox"/> Spirituality  |
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Illness/disability | <input type="checkbox"/> Stress        |
| <input type="checkbox"/> Boundaries     | <input type="checkbox"/> Incarceration      | <input type="checkbox"/> Suicide       |
| <input type="checkbox"/> Childlessness  | <input type="checkbox"/> Life style choices | <input type="checkbox"/> Abortion      |
| <input type="checkbox"/> Death          | <input type="checkbox"/> Loneliness         | <input type="checkbox"/> Other:        |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Loss               | _____                                  |

Please summarize the need that brings you here; continue on back if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you could name two emotions right now to describe your feelings what would they be?

\_\_\_\_\_

Thank you for being here. Your presence is a confirmation that this program is needed. It is our prayer that you will receive a measure of peace about your situation as you share your story with one of our "caring partners" providing peer support. We want you to feel comfortable as you share, knowing that anything you say will be kept confidential. We will make every effort to connect you with someone who has been through a similar situation or cares deeply for what you are experiencing, and has experienced healing.

Our "caring partners" are not professionals and should not be a substitute for professional psychological, psychiatric or medical care. They are trained volunteers here to share with and support you.

**Please sign here to show you have read this and understand this is a program operated by volunteers.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Client

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Volunteer Peer Counselor (VPC)

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**VPC - Check one when meet your client:** (for statistical purposes only)

Single  Married  Live-in partner  Separated  Divorced  Widowed

African American  Asian/Pacific  Caucasian  Hispanic/Latino  Native American

Other

**Site Director Assignment or VPC initial contact notes:**