INTAKE FORM

CLIENT NAME: _____ **DATE:** _____

IDENTIFYING INFORMATION: *DOB _____ □ MALE □FEMALE

Identities (Ethnicity, Sexual Orientation, Religious)_____
_____

Relationship Status: □ Single □ In Committed Relationship □ Separated
□ Partnered/Married □ Cohabitating/Unmarried □ Divorced □ Widowed

Do you have any children? □ No □ Yes If Yes, how many?_____

Referred by: □ Self □ Friend □ Parent/Relative □ Attorney □ Other

PRESENTING PROBLEM AND SYMPTOMS:
_____
_____
_____
_____
_____

How long has this been a problem? _____

WHAT DO YOU HOPE TO EXPERIENCE WITH COUNSELING? (GOALS)
_____
_____
_____
_____

Please list your strengths (Character/Personality):
_____
_____
_____

CONCERNS:	**PAST**	**PRESENT/RECENT**	**EXPLAIN:**
Sleeping Concerns	□ N □ Y	□ N □ Y	_____
Weight or Eating Concerns	□ N □ Y	□ N □ Y	_____
Trauma/Abuse	□ N □ Y	□ N □ Y	_____
Alcohol Use	□ N □ Y	□ N □ Y	_____
Drug Use	□ N □ Y	□ N □ Y	_____

CONCERNS: **PAST** **PRESENT/RECENT** **EXPLAIN:**

Other Addictive Behaviors (Internet, Sex, Gambling…) □ N □ Y □ N □ Y _____

Current Suicidal Thoughts □ Never □ Rarely □ Sometimes □ Often

Past Suicidal Thoughts □ Never □ Rarely □ Sometimes □ Often

Suicide Attempts □ N □ Y If Yes, when: _____

Thoughts about Harming Others □ Never □ Rarely □ Sometimes □ Often

Self-Harming Behaviors (i.e. cutting, burning self, hair pulling)

_____

FAMILY BACKGROUND: Family Status: □ Intact □ Divorced □ Separated □ Other

Family History of Mental Illness/Other Disorders:

_____

How many siblings do you have? _____

Relationship with Mother Described As: □ Good □ Close □ Supportive □ Distant □ Strained

Relationship with Father Described As: □ Good □ Close □ Supportive □ Distant □ Strained

_____

_____

Do you feel that you currently have adequate social support? □ N □ Y Explain:

OCCUPATION:

Are you currently employed? □ Yes, full-time □ Yes, part-time □ No

If yes, how long have you been employed? _____

Occupation: _____

Are you currently a student? □ Yes □ No If so, where? _____

Are you currently receiving disability? □ Yes □ No

Have you ever been terminated from employment? □ Yes □ No

Have you been referred by your job's EAP service? □ Yes □ No

LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT:

Have you ever been charged with a crime, other than minor traffic offenses? □ Yes □ No

If yes, please explain:_____

Have you ever had any involvement with the Department of Children and Families or a similar agency in another state? □ Yes □ No

Have you ever been involved in domestic violence? □ Yes □ No

Are you currently on probation? □ Yes □ No

MEDICAL HISTORY:

Do you currently suffer from chronic or frequent pain? □ Yes □ No

Do you have any of the following medical conditions?

Diabetes □ Yes □ No Hypo/Hyper thyroidism □ Yes □ No

PeriMenopause (women only) □ Yes □ No Frequent Headaches □ Yes □ No

How would you describe your current health? □ Excellent □ Good □ Fair □ Poor

IS THERE ANY OTHER PERTINENT INFORMATION YOU WOULD LIKE ME TO KNOW: (Academic/work issues, disability, medical problems, childhood info, legal/conduct issues, living situation, etc.)

_____

_____

_____

PREVIOUS COUNSELING/PSYCHIATRIC HISTORY:

I have had…

□ **No** Previous Treatment/Counseling □ Previous Counseling □ Psychiatric Treatment

If you have had previous counseling, how would you describe this experience?

_____

□ Past Hospitalizations (When, where, how, and how many) _____

□ Medication(s) _____

Explain any of the above:

_____

Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add or note details in the space next to the concerns checked.

❒ Abuse—physical, sexual, emotional, neglect (of yourself or someone else)
❒ Aggression, violence
❒ Alcohol use
❒ Anger, hostility, arguing, irritability
❒ Anxiety, nervousness
❒ Attention, concentration, distractibility
❒ Career concerns, goals, and choices
❒ Childhood issues (your own childhood)
❒ Codependence
❒ Compulsions
❒ Decision making, indecision, mixed feelings, putting off decisions
❒ Depression, low mood, sadness, crying
❒ Divorce, separation
❒ Drug use—prescription medications, over-the-counter medications, street drugs
❒ Eating problems—overeating, under-eating, appetite, vomiting, emptiness
❒ Failure
❒ Fatigue, tiredness, low energy
❒ Fears, phobias
❒ Financial or money troubles, debt, impulsive spending, low income
❒ Gambling
❒ Grieving, mourning, deaths, losses, divorce
❒ Headaches, other kinds of pains
❒ Health, illness, medical concerns, physical problems
❒ Inferiority feelings
❒ Interpersonal conflicts
❒ Impulsiveness, loss of control, outbursts
❒ Legal matters, charges, suits
❒ Loneliness
❒ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations
❒ Menstrual problems, PMS, menopause
❒ Mood swings
❒ Motivation, laziness
❒ Obsessions, compulsions (thoughts or actions that repeat themselves)
❒ Over sensitivity to rejection
❒ Panic or anxiety attacks
❒ Parenting, child management
❒ Perfectionism
❒ Procrastination, work inhibitions, laziness
❒ Pregnancy (infertility, miscarriage, termination/abortion)
❒ School problems
❒ Self-esteem
❒ Self-harm (cutting, burning, etc.)
❒ Self-neglect, poor self-care

❒ Sexual issues, dysfunctions, conflicts, desire differences, gender concerns, other
❒ Shyness, over sensitivity to criticism
❒ Sleep problems—too much, too little, insomnia, nightmares
❒ Smoking and tobacco use
❒ Spiritual, religious, moral, ethical issues
❒ Stress, relaxation, stress management, stress disorders, tension
❒ Suicidal thoughts
❒ Weight and diet issues
❒ Withdrawal, isolating
❒ Work problems, employment, work holism/overworking, can't keep a job, dissatisfaction, ambition
❒ Any other concerns or issues:

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____