INTAKE INFORMATION

Not all of the questions will apply to you, and you might choose to omit some answers. Please print clearly and bring it with you to the first session.

Today's date_____

Legal Name_____ DOB _____/____/_____

Preferred name: _____ Gender: _____Pronouns: _____Age_____

Contacts: (home) ☐ _____ (cell) ☐ _____

(e-mail ☐ _____

Please check the box if you give your counselor permission to leave a message at this contact.

Address_____

_____

Mailing address if different: _____

Occupation _____Employer_____

_____

Emergency Contact: _____ Phone _____

How did you hear about Jean?_____

Are you currently in school? If so, where? _____

Are you a military veteran?_____

Are you currently involved in the legal system, including custody disputes? _____

Religious Preference (if applicable) _____

Highest grade/degree completed: _____

Current relationship status: ☐single ☐engaged ☐married ☐committed relationship
☐domestic partner ☐separated ☐divorced ☐remarried ☐widowed

Name of current counselor/therapist? _____

Have you had counseling in the past?: ☐ yes ☐ no When?_____
Was it helpful? How so? _____

_____

PRESENTING ISSUES (be as specific as you can: when it started, how it affects you):

_____

_____

_____

The issues are currently: Mild ____ Moderate ____ Severe ___Very severe ____

What have you tried thus far to resolve these issues?_____
_____

What do you hope to accomplish through therapy?_____
_____

_____

Primary Care Physician (Name, date last seen): _____
Address:_____
Phone:_____
I want my counselor to share information with my PCP if need for care: _____Yes _____No
Current health conditions: _____
_____
Allergies: _____

Significant medical history (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

CURRENT MEDICATION	DOSAGE	PRESCRIBER	REASON FOR TAKING

What mental health medications have you taken in the past?_____
_____

Describe the quality of your sleep?_____

_____

How is your appetite? _____

Do you exercise? What type and how often?_____

_____Su

Substance Use

Tobacco (any form) ☐current ☐past ☐never ☐occasionally Amount_____

Alcohol ☐current ☐past ☐never ☐occasionally Amount_____

Marijuana ☐current ☐past ☐never ☐occasionally Amount_____

Street/Recreational/Non-prescribed drugs:

☐current ☐past ☐never ☐occasionally Amount_____

Have you participated in drug or alcohol abuse treatment, including AA or NA?: _____

Are you concerned about your drug or alcohol intake?_____

Is anyone close to you concerned about your drug or alcohol intake? _____

Are there immediate or extended family members with alcohol or substance abuse issues? _____

_____

Have you ever contemplated or attempted suicide (when, why, how)_____

_____

Do you currently feel like harming yourself, or committing suicide?_____

Describe any past or current self-injury (cutting, scratching, pulling out hair, etc)? _____

_____

Did/do you have any thoughts of violence against others?_____

Have you ever experienced a psychiatric hospitalization? _____

Are there immediate or extended family members with depression, anxiety, ADHD, Asperger's/autism or other mental health issues? _____

_____

List any citations and arrests. _____

Are you involved with DHS? _____

Names of all current household members		Age	Gender	Relationship
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

**Please check the box if there are special living/ custody circumstances related to this person.*

Present spouse/partner (if applicable) level of education and occupation:

_____

Describe your current partner relationship: _____

_____

_____

Children: List each child's name of top of each column. Include step- and foster children.

Child's name						
Age						
Other parent's name						
Adopted child? Check if yes.						
Step child? Check if yes.						
Foster child? Check if yes.						
Lives with you? Check if yes.						
Medical concerns? Check if yes.						
Social concerns? Check if yes.						
Behavior concerns? Check if yes.						
Academic concerns? Check if yes.						
Deceased? Check if yes.						

Family of Origin

Were you adopted? If so, at what age? _____

By whom were you primarily raised? _____

_____

Were you separated from your parents as a child? _____

Parents or primary caregivers: Relationship (e.g. mother, father), current age or year & cause of death, occupation, personality, description of the relationship during childhood:

Parent/parent figure 1:_____

_____

_____

_____

Parent/parent figure 2:_____

_____

_____

_____

From oldest to youngest, list your siblings.

Sibling's name						
Age						
Lived with you during childhood?						
Half-sib? M for mom's, F for father's						
Step-sib? M for mom's, F for father's						
Adopted sib? Check if yes.						
Foster sib? Check if yes.						
Medical concerns? Check if yes.						
Social concerns? Check if yes.						
Behavior concerns? Check if yes.						
Academic concerns? Check if yes.						
Deceased? Check if yes.						

Describe your childhood and childhood self, in general:

_____

_____

_____

IF YOUR PARENTS DIVORCED, your age at the time: _____.
Describe how it affected you _____

_____

Describe your teen years and teenage self, in general:

_____

_____

_____

Please give information on past and current serious romantic relationships, including long-term dating, co-habitating and marriage.

First name	Type of relationship	Your age when rel. began	Length of rel.	How rel. ended

Current relationship with parents:_____

_____

Any serious conflicts/rifts with parents during your adult years?_____

Have you had any difficulties around fertility, pregnancy or birth? _____

Have you been physically abused or been involved in domestic violence?_____

Have you been sexually abused?_____

Have you been verbally abused?_____

Describe your present social involvement, friendships and organizational involvements_____

_____

_____

Do you feel your technology use is balanced and healthy or could it use improvement? Please explain: _____

_____

Major losses or traumas you have experienced	Time frame

What do you enjoy doing?_____

_____

_____

Please use the numbers below to indicate how difficult this area of life is for you currently.

0= None 1= Low 2= Moderate 3= High

☐ Job ☐ Finances ☐ Health ☐ Leisure time/hobbies ☐ School
☐ Partner relationship ☐ Family of Origin/ childhood ☐ Grief and/or loss
☐ Emotional abuse ☐ Physical abuse ☐ Sexual abuse
☐ Current extended family relationships ☐ Relationships with your children
☐ Social life ☐ Other parenting issues (behavior management, special needs, etc.)
☐ Alcohol abuse or drug use ☐ Addiction and recovery ☐ Aggression
☐ Sexuality ☐ Preoccupation with sex ☐ Sexual addiction ☐ Anger
☐ Feeling of unreality (e.g. feeling outside your body) or hallucinations
☐ Mania-like episodes (consecutive days of very high energy with little need for sleep)
☐ Obsessive or compulsive behaviors (including impaired impulse control)
☐ Excessive guilt or shame ☐ Excessive shyness ☐ Low self esteem

In addition to numbering, please underline words or phrases that apply to you.

☐ Eating (too much, too little, anorexia, bulimia, binge eating)
☐ Sleep (too much, too little, insomnia, nightmares)
☐ Emotions (hard to control, stuffed down, mood swings, unexplained crying)
☐ Self-control (anger, aggression, impulsivity, overly talkative, restless)
☐ Anxiety (worry, fear, guilt, edgy, overwhelmed, can't relax) ☐ Panic
☐ Depression (sad, irritable, unmotivated, low energy, feeling worthless, withdrawing)
☐ Self harm (suicidal thoughts or plans, cutting or other self-injury)
☐ Thoughts (disorganized, racing, unwanted, obsessive, disturbing)
☐ Thinking (unable to make decisions, memory loss, trouble concentrating)
☐ Trust issues (feel abandoned, used, others are out to get me, talked about, watched)
☐ Other _____

What is going well for you?_____

_____

_____

What are your most satisfying accomplishments?_____

_____

_____

What are your strengths? What do you or others notice or appreciate about you? What are the personal, internal resources that you use to cope with life stress?_____

_____

_____