

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 _____

Name _____ Age _____ DOB ____/____/____

Contacts: (home) _____ (cell) _____

(e-mail _____)

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

Address _____

Mailing address if different: _____

Occupation _____ Employer _____

If unemployed, not working outside the home or retired, what was the nature of your last job?

Emergency Contact: _____ Phone _____

Referred by? _____

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

Military history- branch, years of service, deployments, honors: _____

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

Have you had counseling in the past?: yes no When? _____

Was it helpful? How so? _____

PRESENTING ISSUE (be as specific as you can: when did it start, how does it affect you.):

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ____ Very severe ____

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

What do you hope to accomplish through therapy? _____

Are you currently working with another counselor/therapist? _____

Primary Care Physician (Name, date last seen): _____

Address: _____

Phone: _____

Current health conditions: _____

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? _____

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 you ever 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 household members	Age	Gender	Relationship
_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	_____

**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? <small>Check if yes.</small>						
Step child? <small>Check if yes.</small>						
Foster child? <small>Check if yes.</small>						
Lives with you? <small>Check if yes.</small>						
Medical concerns? <small>Check if yes.</small>						
Social concerns? <small>Check if yes.</small>						
Behavior concerns? <small>Check if yes.</small>						
Academic concerns? <small>Check if yes.</small>						
Deceased? <small>Check if yes.</small>						

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), name/age or year/cause of death, occupation, personality, description of the relationship during childhood:

Caregiver 1: _____

Caregiver 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 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 serious relationships, including long-term dating, co-habiting, marriage, etc.

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

Current relationship with parents: _____

Any serious conflicts/rifts 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? _____

1. Please indicate your degree of concern with the following areas of your life.

2. Underline words or phrases that apply to you.

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
 Sexuality Preoccupation with sex Sexual addiction
 Eating (too much, too little, anorexia, bulimia, binge eating)
 Sleep (too much, too little, insomnia, nightmares) Anger Aggression
 Low self esteem Excessive guilt or shame Excessive shyness
 Emotions (hard to control, stuffed down, mood swings, unexplained crying)
 Self-control (anger, aggression, impulsivity, overly talkative, restless)
 Anxiety (worry, fear, guilt, edgy, overwhelmed, panic, can't relax)
 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)
 Obsessive or compulsive behaviors (including impaired impulse control)
 Trust issues (feel abandoned, used, others are out to get me, talked about, watched)
 Feeling of unreality (e.g. feeling outside your body) Hallucinations
 Mania-like episodes (several days of very high energy with little need for sleep)
 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? _____
