

Intake Form

Date _____ Last Name _____ First Name(s) _____

Address _____ City _____ State _____ Zip _____

Do I have permission to send mail to this address? Y / N

E-mail Address: _____

Telephone: Home _____ Cell _____ Work _____

Male Female Couple Date of Birth ___/___/___ (Partner DOB ___/___/___)

Is it acceptable to contact you at home by phone? Y / N By cell phone? Y / N

If none of the above options is acceptable, how may I contact you? _____

How did you hear of me? If you found me on the web, through what site?

Who may I thank for referring you? _____

Please check any current general issues or past issues that still affect you.

- | | |
|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fears/phobias (type: _____) | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Separation/divorce | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Drug/alcohol use | <input type="checkbox"/> Career Choices |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Self-Control |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Religious matters | <input type="checkbox"/> Work/Stress |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Cutting/Self-harm |
| <input type="checkbox"/> Thought patterns (type: _____) | <input type="checkbox"/> Pregnancy Issues |
| <input type="checkbox"/> Death of someone close | <input type="checkbox"/> Relationship Concerns |
| <input type="checkbox"/> recently (when: _____) | <input type="checkbox"/> family |
| <input type="checkbox"/> in the past | <input type="checkbox"/> friend |
| <input type="checkbox"/> Sexual assault/rape | <input type="checkbox"/> parent |
| <input type="checkbox"/> recently (when: _____) | <input type="checkbox"/> significant other |
| <input type="checkbox"/> in the past | <input type="checkbox"/> roommate |
| <input type="checkbox"/> Childhood abuse | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> Sexual identity issues | <input type="checkbox"/> Academic Issues |
| <input type="checkbox"/> Pornography | <input type="checkbox"/> Conduct problems |
| <input type="checkbox"/> Other _____ | |

Your Current Functioning

Please describe the particular issue(s) that have brought you to counseling. Briefly include any relevant information on when these problems began, how often they occur, and/or the severity of these issues.

What do you hope to get out of counseling?

Who provides you with social and emotional support? How do you describe your network of friends?

What do you do to relax and enjoy yourself?

Work and Education

Please provide a brief history of your employment, including your current position if you are employed. Are you happy with your work now?

Describe your educational experience (last grade completed, grades, problems).

Family of Origin

Who was present in your family during your childhood?

	Present entire childhood	Present part of childhood	Not present at all
mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stepfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe your parents:

Father

Mother

Name _____
 Occupation _____
 Education _____
 General health _____

Parents' current marital status:

- married to each other
- separated for _____ years
- divorced for _____ years
- mother remarried _____ times
- father remarried _____ times
- mother involved with someone
- father involved with someone
- mother deceased for _____ years
your age at mother's death _____
- father deceased for _____ years
your age at father's death _____

Describe your childhood family experience:

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed phys./verbal/sexual abuse toward others
- experienced physical/verbal/sexual abuse from others

Age you left home: _____ Circumstances:

Special circumstances in childhood?

Immediate and Extended Family

What is your current family structure (marital status, children, others living in home)? Also, describe any history of previous marriages, children, stepchildren, or other significant relationships.

Please mark any issues that are present in your family, including extended family:

Issue	Family member(s)
_____ Mental illness (incl. depression and anxiety)	_____
_____ Birth defects	_____
_____ Chronic illness	_____
_____ Hereditary illness	_____
_____ Alcoholism	_____
_____ Drug abuse	_____
_____ Physical abuse	_____
_____ Sexual abuse	_____
_____ Behavior problems	_____

Medical Health / History

Are you currently under medical care? If yes, please explain/describe:

Do you have health concerns that are untreated at this time? If yes, please describe:

Name of primary physician: _____ Phone number: _____

Medical Health / History (cont.)

Are you currently taking prescribed medications? **Y / N** Please explain/describe, including dosage:

List psychiatric/mental health medications you have taken in the past, including herbal substances:

Please list any time(s) in which you received care from a psychiatrist, psychologist, or counselor:

<u>Clinician</u>	<u>Location</u>	<u>Date</u>	<u>Nature of problem/ Diagnosis</u>
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Are you or have you ever been suicidal? Briefly note dates and whether you have attempted suicide.

How often do you drink alcohol? _____ times per _____ (week, month, etc.)

How many drinks do you have each time you drink? _____

Has anyone (you or others) expressed concern about your use of alcohol?

Do you use other drugs/substances? _____ How often? _____ times per _____

Has anyone (you or others) expressed concern about your use of other drugs/substances?

Are you in a relationship in which you have been hit or threatened or forced to have sex? Is there anyone you're afraid of?

Specific Symptoms

Please rate your experience of the following specific symptoms using the key below. It is a lengthy list, but it can help you and your therapist to identify specific problems.

Never = 0; Seldom = 1; Often = 2; Always = 3

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Memory loss/blackout | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Vision or hearing problems | <input type="checkbox"/> Crying | <input type="checkbox"/> Missing classes |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Feeling helpless | <input type="checkbox"/> Anger | <input type="checkbox"/> Feeling uptight |
| <input type="checkbox"/> Eating binges | <input type="checkbox"/> Worrying | <input type="checkbox"/> Lack of interest |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Feeling afraid | <input type="checkbox"/> Guilt feelings |
| <input type="checkbox"/> Lying to others | <input type="checkbox"/> Withdrawing socially | <input type="checkbox"/> Feeling out of control |
| <input type="checkbox"/> Sexual preoccupation | <input type="checkbox"/> Feelings of self-doubt | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Nervous around others | |
| <input type="checkbox"/> Injuring self <i>List:</i> _____ | | |

- | | | |
|--|---|--|
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Impulsivity | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness/Faintness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Sweating | <input type="checkbox"/> Sensation of choking |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness | <input type="checkbox"/> Hot flashes/chills |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Fear of "going crazy" |
| <input type="checkbox"/> Panic attacks | | |

- | | | |
|--|---|--|
| <input type="checkbox"/> Muscle tension/ache | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Feeling "on edge" |
| <input type="checkbox"/> Easily startled | | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Recurrent dreams | <input type="checkbox"/> Intrusive recollections | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Difficulty feeling emotions | <input type="checkbox"/> Lack of sense of future |
| <input type="checkbox"/> Physiological reaction to trauma reminders | <input type="checkbox"/> Avoidance of certain memories | |
| <input type="checkbox"/> Difficulty recalling aspects of past trauma | <input type="checkbox"/> Distress to trauma reminders | |

Physical symptoms (e.g., headaches, digestive) Have you seen a health care provider for these? _____

Sexual functioning problems Have you seen a health care provider for these? _____

Other: _____ Other: _____

Emergency Notification

In case of emergency, notify:

Name: _____

Address: _____

Cell Phone: () _____

Home Phone: () _____

Relationship: _____

OR

Name: _____

Address: _____

Cell Phone: () _____

Home Phone: () _____

Relationship: _____

Client Signature: _____

Date: _____