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.

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

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	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other (specify)	☐	☐	☐

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:

Clinician	Location	Date	Nature of problem/ Diagnosis

_____
_____

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

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

_____ Irritability
_____ Racing thoughts
_____ Decreased need for sleep
_____ Impulsivity
_____ Difficulty sleeping

_____ Shortness of breath
_____ Trembling/shaking
_____ Nausea
_____ Chest pain
_____ Panic attacks
_____ Dizziness/Faintness
_____ Sweating
_____ Numbness
_____ Fear of dying
_____ Palpitations
_____ Sensation of choking
_____ Hot flashes/chills
_____ Fear of "going crazy"

_____ Muscle tension/ache
_____ Frequent urination
_____ Easily startled
_____ Restlessness
_____ Trouble swallowing
_____ Dry mouth
_____ Feeling "on edge"

_____ Recurrent dreams
_____ Hallucinations
_____ Intrusive recollections
_____ Difficulty feeling emotions
_____ Flashbacks
_____ Lack of sense of future
_____ Physiological reaction to trauma reminders
_____ Difficulty recalling aspects of past trauma
_____ Avoidance of certain memories
_____ 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: _____