COUNSELING INTAKE FORM

The information on this form is very important and I will be reviewing it with you. It is essential to the success of your treatment that I understand as much about you as possible. Please answer the questions as honestly as you can, and feel free to explain or add any other information. If a question does not apply to you, please write N/A.
This information, like ALL information you give me, is confidential.

Name: _____ Date: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: F M
Street Address: _____
City: _____ Zip: _____ County: _____
Cell Phone: _____ Home Phone: _____
Email: _____

Emergency Contacts
Name: _____ Relationship: _____
Phone Number(s): _____
Name: _____ Relationship: _____
Phone Number(s): _____

Employment
Current Employer: _____
Job Title: _____
Work Phone: _____ Length of time at current job: _____

Family
Relationship Status *(circle all that apply):*
Single Partner Married Separated Divorced Widowed Remarried
Biological Children, *if applicable* (include age and gender):
_____
_____

Other
Highest Educational Level: _____
If College Graduate, Degree and Major: _____
Hobbies/Interests: _____
_____

Are you: □Religious □Spiritual □Neither

Have you ever served in the Military? □ No □ Yes
If Yes: Branch: _____ When: _____

Have you ever been convicted of a crime? □ No □ Yes-Explain: _____
_____
Are you on: □ Probation? □ Parole? PO's Name: _____

GENERAL HEALTH

Smoker: □No □Yes-How much per day? _____ For how long? _____
Drinker: □No □Yes-How much per day? _____ Age of first drink: _____
Illegal drug use: □No □Yes-What? _____
Exercise: □Never □1-2 times/week □3-4 times/week □5-7 times/week
Overall Diet: □Very Healthy □Moderately Healthy □Average □Unhealthy □Poor
How satisfied are you with your overall health?
□Highly Satisfied □Satisfied □Neutral □Dissatisfied □Very dissatisfied
Are you interested in nutritional health coaching as a supplement to therapy?
□Yes □No □Maybe

MEDICAL/MENTAL HEALTH HISTORY

Current Medication(s)	Dosage	Frequency	Prescribed by

Any Unwanted Side Effects? □ No □ Yes-Describe: _____
_____
Psychotropic Medications Previously Prescribed: _____
_____
Primary Care Physician: _____
Last Physical Exam: _____ Results: _____
Your Current Physical Health: □Poor □Satisfactory □Excellent
Hospitalizations: _____
Surgeries:_____
Accident/Injuries: _____
Current Medical Problems or Persistent Physical Symptoms *(chronic pain, headaches, hypertension, diabetes, etc):* _____
_____
_____
_____
_____

Please indicate if you or anyone in your family (include siblings, parents, grandparent, aunts, uncles, and cousins) have a history of (check all that apply and indicate relationship to family member where applicable):

Self	Family	
		High blood pressure
		High cholesterol
		Heart attack (age occurred)
		Asthma, other lung problems
		Migraines/other neurologic
		Cancer (list type)
		Diabetes
		Thyroid disease

		Head injury
		Seizures
		Depression
		Bipolar Disorder
		Anxiety/OCD
		Eating disorder
		ADHD
		Autism/Asperger's
		Schizophrenia (or other psychotic disorder)
		Suicide
		Self-harm
		Personality disorder
		Alcoholism/drug addiction
		Sexual abuse
		Physical abuse
		Emotional/verbal abuse
		Neglect
		Domestic violence
		DCS involvement
		Frequent moving
		Homelessness
		Criminal History

List any other major life stressors (e.g., death of family member, unemployment, major accident, house fire, crime victim, etc.) that you have faced during your life and when:

_____

_____

_____

Have you ever been hospitalization for mental health reasons? □No □Yes

Have you previously seen a mental health professional (therapist/counselor/psychologist/ psychiatrist)? □ No □ Yes

Have you experienced any significant changes in your life recently? □No □Yes – please describe: _____

_____

SOCIAL/RELATIONSHIP HISTORY

If you are currently in a relationship or marriage, how long? _____

How satisfied are you in your relationship? *(Very Dissatisfied) 1--2--3--4--5 (Very Satisfied)*

Are you experiencing any sexual difficulties? □ Yes □ No

Describe any areas of conflict with your partner: _____

_____

_____

How many close friendships do you have? _____
Do you turn to your friends when you need help or support? □ Yes □ No

PRESENTING CONCERNS / COUNSELING GOALS

1. What concerns have caused you to seek counseling at this time?
   _____
   _____
   _____
   _____
   _____

2. How much distress have you been experiencing from the above concern(s)?
   (mild) 1-----2-----3-----4-----5 (severe)

3. How long have you been feeling this way? _____

4. Until now, what have you tried to do to cope with your distress? _____
   _____
   _____
   _____

5. Did anything ***that you're aware of*** precipitate your present concerns? □ Yes □ No
   If yes, please describe: _____
   _____

6. What are your goals for counseling? *(please be as specific as possible)* _____
   _____
   _____
   _____

7. How long do you expect counseling to last? _____

8. Any other information that might be helpful for me to know about you that I haven't asked? _____
   _____
   _____
   _____
   _____

CURRENT SYMPTOM CHECKLIST

Please place a check mark in the box next to any symptom you are <u>currently experiencing or have experienced in the past few weeks.</u>

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Sleep too much
- ☐ Feeling tired all the time
- ☐ Nightmares or night terrors
- ☐ Feel a sense of dread
- ☐ Feel I have no future
- ☐ Isolation/social withdrawal
- ☐ Mood swings
- ☐ Lower sex drive
- ☐ Agitation or nervousness
- ☐ Muscle tension or soreness
- ☐ Stomach nausea or upset
- ☐ Have to check and re-check
- ☐ Worry about what others think
- ☐ Compare myself to others
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors
- ☐ Feel my life is out of control
- ☐ Afraid something is wrong w/ me
- ☐ Faintness or dizziness
- ☐ Easily annoyed or irritated
- ☐ Pain in heart or chest
- ☐ Feel over-sensitive
- ☐ Heart pounds or races
- ☐ Feel inferior to others
- ☐ Difficulty making decisions
- ☐ Afraid to go out in public
- ☐ Avoid certain things
- ☐ Have frightening/disturbing thoughts
- ☐ Feel something bad will happen
- ☐ Have unrealistic fears
- ☐ Worry a lot
- ☐ Feel hopeless/helpless
- ☐ Appetite changes
- ☐ Overspending
- ☐ Gambling problems
- ☐ Racing thoughts
- ☐ Frequent headaches
- ☐ Feel panicky or terrified
- ☐ Uncomfortable memories
- ☐ Disturbing flashbacks
- ☐ Feel disconnected from reality
- ☐ Dislike my body
- ☐ Feel guilty
- ☐ Feel ashamed
- ☐ Cry often
- ☐ Feel life is not worth living
- ☐ Temper outbursts
- ☐ Low energy
- ☐ Body aches and pains
- ☐ Feel lonely
- ☐ Perfectionist
- ☐ Shortness of breath
- ☐ Enjoy things less
- ☐ Self-conscious
- ☐ Fearful when driving
- ☐ Trouble concentrating
- ☐ Feel worthless
- ☐ Argumentative
- ☐ Dislike crowds
- ☐ Difficulty remembering things
- ☐ Feel suicidal
- ☐ Low self-esteem
- ☐ Stress or tension
- ☐ Thoughts of hurting myself
- ☐ Thoughts of hurting someone
- ☐ Cutting or self-injury
- ☐ Alcohol or drug abuse
- ☐ Poor anger management
- ☐ Blackouts
- ☐ Restrictive eating
- ☐ Binging and/or purging
- ☐ Depression/sadness

Please list any other symptoms that you're experiencing that would be helpful for me to know.