

Individual Intake

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Place an asterisk (\*) next to all numbers at which it is ok to leave messages.

Please list your family members:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** | page1image43991616**Date of Birth:** | page1image43986560page1image43985792**Relationship:** | page1image43986368**Lives with you?** | page1image58603968**Work/School:** |
|  | page1image43988096page1image43989056 | page1image43987520page1image43990208page1image43960768page1image43958272 | page1image43958848page1image43974208 | page1image43973824page1image43973248 |
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Please provide the following information and answer the questions below.  
**Please note:** Information you provide here is protected as confidential information.

What is the main reason you have decided to seek counseling at this time? page1image43964416page1image43944192page1image43944384page1image43942272page1image43942080page1image43944192page1image43944384page1image43942272page1image43942080page1image43944192page1image43944384page1image43942272page1image43942080page1image43944192page1image43944384page1image43942272page1image43942080

Please check all that apply to your current situation or struggle:

□ Stress  
□ Anger  
□ Fears  
□ Finances

□ Parenting

□ Guilt

□ Anxiety  
□ Depression

□ Hopelessness  
□ Extreme sadness  
□ Physical pain  
□ Memory problems

□ Grief and loss  
□ Impulsive behavior

□ Financial problems

□ Legal matters

□ Obsessions or compulsions

□ Trouble concentrating  
□ Self-esteem problems  
□ Relational problems

□ Trouble making decisions  
□ Changes in sexual interest or function □ Thoughts about harming others  
□ Lack of enjoyment of usual activities

Have you previously received any type of mental health services (counseling, psychiatric services, hospitalizations, etc.)?  
□ No  
□ Yes Previous therapist/practitioner: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever had thoughts of harming yourself?  
□ No  
□ Yes If so, when: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever attempted suicide or made suicidal gestures?  
□ No  
□ Yes If so, when: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list any prescription medications you are currently taking:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication name:** | page2image43983488**Dosage:** | **Reason it was prescribed:** | page2image58546416**Date originally prescribed:** |
|  |  |  | page2image43832192 |
|  | page2image43839680 |  | page2image43817728 |
|  | page2image43814080 |  | page2image43866496 |
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Please list any psychiatric medications you have ever been prescribed:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication name:** | page2image43983488**Dosage:** | **Reason it was prescribed:** | page2image58546416**Date originally prescribed:** |
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|  | page2image43839680 |  | page2image43817728 |
|  | page2image43814080 |  | page2image43866496 |
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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor | Unsatisfactory | Satisfactory |Good | Very Good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? (Please circle)

Poor | Unsatisfactory | Satisfactory | Good | Very good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** What types of exercise do you participate in? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

4. Please list any difficulties you experience with your appetite or eating patterns: **page2image43521280page2image43521088page2image43521280**

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes If yes, for approximately how long? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes If yes, when did you begin experiencing this?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

7. Are you currently experiencing any chronic pain?

□ No □ Yes If yes, please describe?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

8. Do you drink alcohol?

□ No □ Yes How many drinks per week? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

9. Do you drink caffeinated beverages?

□ No □ Yes If yes, how many drinks per week? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

10. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. Are you currently in a romantic relationship? □ No □ Yes  
If yes, for how long? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** On a scale of 1-10, how would you rate your relationship? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

12. Have you experienced abuse (physical, emotional, or sexual) As a child? □ No □ Yes

As an Adult? □ No □ Yes Explain:

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13. What significant life changes or stressful events have you experienced recently?

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14. What significant traumatic events have you experienced in your life?

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FAMILY MENTAL HEALTH HISTORY:  
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

Please List Family Member(s) Alcohol/Substance Abuse:

□ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety: □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autism Spectrum Disorder: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depression: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Obsessive Compulsive Behavior: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schizophrenia: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the relationship you currently have with the family you grew up in:

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes  
Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest grade of education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you enjoy your work? Is there anything stressful about your current work? page1image43944192page1image43942272page1image43942080

3. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief: page1image43942272page1image43944192page1image43942080page1image43944192page1image43942080page1image43944192page1image43942080

3a. Do you desire to incorporate your faith into your therapy? If yes, please describe what feels safe and positive for you.

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4. What do you consider to be some of your strengths?

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5. What do you consider to be some of your weakness?

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6. What do you do for fun or to relax? page1image43944192page1image43942272page1image43942080

7. What would you like to accomplish out of your time in therapy? page1image43944192page1image43942272page1image43942272page1image43944192page1image43942080

8. Is there anything else you would like me to know? page1image43944192page1image43942272page1image43942080page5image43524160page5image43525504page5image43525696page5image43525888page5image43526080page5image43526272page5image43526464page5image43526656page5image43526848page5image43527040page5image43527232page5image43527424page5image43527616page5image43527808page5image43528000