

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:** |
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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? 

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:** |
|  |  |  | page2image43832192 |
|  | page2image43839680 |  | page2image43817728 |
|  | page2image43814080 |  | page2image43866496 |
|  | page2image43566784 |  | page2image43568704page2image43569280 |

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:



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: ****

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:



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



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



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:



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? 

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

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





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



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



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

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

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