COUNSELING INTAKE FORM

Name: _____ Date: _____
Best Contact Phone Number(s):_____
Marital Status:_____ Months/Years: _____

Children: Name and Age (If child is deceased, please indicate name, age, year.)

_____
_____
_____

General Health: Excellent Good Average Fair Poor
Smoke: Y N Drink: Y N Drugs: Y N
*If yes for any of the three, what kind, how much, and how long?*_____
_____

Significant medical conditions: _____
_____
_____

Previous therapy, counseling, or interventions? Y N If *so, with who, when, and for what?* ____
_____

Have you ever engaged in self-injurious behavior such as cutting or intentional self-harm? Y N
If yes, please explain. _____
_____

Medications, purpose, dosage, time of day, any side effects?
1. _____
2. _____
3. _____
4. _____
5. _____

Life-style habits (ex. exercise, hobbies, fun activities) _____
_____
_____

Family History

Ethnicity_____
Father: Alive Deceased *If deceased, what year?* _____ *Your age?* _____
Describe your relationship: _____
_____

Mother: Alive Deceased *If deceased, what year?*_____*Your age?* _____
Describe your relationship: _____

_____

Parents divorced? Y N Your age? _____ Step-father? _____ Step mother? _____
Describe relationship _____

_____

Siblings:

Name	Age	Name	Age
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Describe relationship(s) _____

_____

_____

In your family, was there any substance abuse, alcoholism, suicide, self-harm, or mental illness?
Physical, verbal, sexual, or emotional abuse? Y N *If yes, please describe.* _____

_____

_____

Any trauma? Y N *If yes, please describe.* _____

_____

_____

Work/ Social/ Educational/ Legal History

Current Occupation: _____ Like OR dislike

Military Service? You or significant other? _____

_____

Current Level of Education: _____

Describe your school experience (friends, bullying, teachers, grades, etc) _____

_____

_____

Have you ever had any legal problems, arrests, or convictions? Y N *If so, please describe.* __

_____

_____

Spiritual History

Religious upbringing _____ Present Affiliation _____

Is this an important part of your life? _____

Would you like for this to incorporated in to your sessions? Y N

Present Situation

What are your reasons for coming in for therapy? Briefly explain the nature of your situation(s). _

_____

_____

_____

_____

Are you experiencing any of the following symptoms?

Anxiety Panic Attacks Depression Unclear Sense of Self

Memory loss Low sense of self-esteem Change of Appetite

Weight gain/loss Flashbacks/nightmares Compulsive behaviors(OCD)

Sleep Disturbances Mood Swings Physical Pain Suicidal Thoughts

Obsessive Thinking

When did the symptom(s) begin? _____

What other people may be contributing to your symptoms or problems? _____

_____

How do you feel about yourself? _____

_____

How do you feel about counseling? _____

_____

Is there anything I haven't asked you that you feel is important for me to know? _____

_____

_____

_____

Please feel free to use the back to provide further information