Intake Form

(Thank you for your thoughtful answers. Please know they will be kept confidential as required by law.)

Date: ______________________________________

Name of Client: ____ If client is a minor, parent's name: _______________________

Client Age: __________ Gender: _____ Race/Ethnicity (opt) ___________________ Religious Affiliation, if any (opt) ________

Please list names and ages of everyone in your household: ____

Concerns

Briefly tell us about the concerns that have brought you here. ____

____

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____

Please check any current or past issues that still affect you (and/or your child).

__ Eating disorders
__ Academic issues
__ Childhood abuse (e.g., physical, sexual, emotional)
__ Stress / anxiety
__ Phobias (type: ________________________________)
__ Alcohol/other drug use
__ Sexual assault / rape
 __ recently (when? __________________________)
 __ in the past
__ Death of someone close
 __ recently (when? __________________________)
 __ in the past
__ Addictions (type:________________________________)
__ Family issues (e.g.., divorce, alcoholism, domestic violence)

__ Pregnancy issues
__ Spiritual concerns
__ Depression
__ Pornography
__ Sexual identity issues
__ Relationship concerns
 __ family
 __ friend
 __ parent
 __ significant other
 __ roommate
 __ other: ___________________________________
__ Financial issues
__ Suicidal thoughts

__ Child behavioral problems: ____
__ Other: ____

Client History

Current medical problems. ____

List all current medications, including herbal. ____

Which medications, if any, have you been on in the past for mental health issues? ___________________________________

Have you previously seen a therapist and/or psychiatrist? ______ Who? When? Issues?__________________________________

Are you currently seeing a therapist and/or psychiatrist? _______ Who? Issues? ______________________________________

Who is your family physician and/or pediatrician? ____

(Note that we will not contact the providers listed above without your permission.)

(Please complete second side)

Have you ever been hospitalized for physical or mental health issues? _____ Briefly describe: ______________________________

____

Have you had any previous suicide attempts? _____ Briefly describe: ____

____

Does anyone in your family have a history of mental/physical health issues? Who? What type? ______________________________

____

Symptoms

If you (and/or your child) currently experience any of the following symptoms, please rate them using the key below:

0 = Never **1 = Seldom** **2 = Often** **3 = Always**

___ Poor school performance
___ Difficulty concentrating
___ Crying
___ Missing work, classes, events, etc.
___ Feeling helpless
___ Feeling uptight
___ Worrying
___ Feeling hopeless
___ Feeling afraid
___ Lying to others
___ Feeling out of control
___ Feelings of self-doubt
___ Injuring self (How: __________________________)
___ Nervous around others
___ Stealing
___ Memory loss or blackout
___ Difficulty sleeping
___ Suicidal thoughts

___ Difficulty getting along with others
___ Anger
___ Negative thoughts about body
___ Consumed with changing your appearance
___ Distressed when exercise routine is disrupted
___ Eating binges
___ Restricting food or not eating
___ Purging/throwing up
___ Drinking heavily
___ Other drug use
___ Guilt feelings
___ Withdrawing socially
___ Sexual preoccupation
___ Physical symptoms (e.g.., headaches, digestive)
List: ____
____
Have you seen a health care provider for these?_______________
___ Other: ____

Are you interested in a counseling group? ________________________ For what issues/topics? ________________________________

Please use this scale to answer the following questions:

1 = True to a great extent **2 = Mostly true** **3 = Somewhat true** **4 = Not at all true**

_____ My current concerns affect my well-being.

_____ My current concerns affect my ability to interact and connect with important relationships in my life.

_____ I am optimistic that I will be able to make some positive changes as a result of counseling.

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