INTAKE FORM

Date of Session:_____

Clients Name/s:_____Age:_____
_____Age:_____
_____Age: _____
_____Age:_____
_____Age:_____

Fee per session:_____

Please check one:

Crisis Intervention: _____ Short Term_____Long Term_____

Please check all that apply:

Individual_____ Couple:_____ Child:_____Family:_____Group:_____

Reasons for seeking Counseling:

1._____
2._____
3._____

Clients Goals:

1._____
2._____
3._____

Adjunctive therapy services recommended:_____

What happened recently to prompt counseling: _____

_____

Family Members Currently in Counseling? _____

Previous Counseling: Y/N

Name: _____ For:_____

Prescription? Nonprescription Meds: Y/N

Name: _____For:_____

Name:_____ For:_____

Name:_____For:_____

Substance Use/Abuse: Types including alcohol, drugs, tobacco, caffeine, food, shopping, gambling:_____

_____

Age of Onset:_____Frequency:_____

Secrecy:_____

Behavior Changes:_____

Attitude towards:_____

Denies all use: Y/N Denies Abuse: Y/N

Date of last use:_____

Arrested or hospitalized due to drugs/alcohol: Y/N

Recognition into problem: Y/N

Willingness to access resources for substance abuse? Y/N

Relatives Use:_____

Attitude toward user:_____

Sex (Exposure to, first time, frequency, protection, abuse, sexuality, attitude towards)__

_____

_____

If male, do you suffer from: Impotence____Premature Ejaculation_____

If female, do you suffer from: Painful intercourse_____Non-Orgasmic_____

Spirituality (Creative expression, enriching experiences, religion):_____

_____

Education (Grade completed, Attendance, GPA, periods of success, difficulties, ditching, homework, activities, expectations, teachers, future):_____

_____

Family (Caretakers, parents, significant support persons-Names and ages):

_____

_____

_____

Sisters and Brothers(Names, ages, relationship with): _____

_____

_____

Role in family(ex: black sheep. maid, hidden child, pseudo parent, clown, star, etc):_____

_____

Others in Home:_____

Parents marriage(length of time,quality):_____

_____

Stepparents:_____

Custody:_____

Fathers Employment(length of time, problems, work hrs):_____

_____

Mothers Employment(length of time, problems, work hrs.)_____

_____

Family Origins/Culture:_____

Hospitalizations(Psych): Y/N
Where:_____Dates:_____
Suicide Attempts: Y/N
Year/Method:_____
Current Suicidal Ideation:
Suicidal Thoughts: Do they manifest: Never____Occasionally____Often_____
Plan:_____Means:_____
Describe current plan:_____

Homicidal Ideation:
Homicidal Thoughts: Occasionally____ Often____Frequently_____
Intended Victim:_____
Means:_____
Legal and Ethical Isues:
Custody:_____
Lawsuits:_____
Workers Comp/Disability:_____
Assess for Child or Elder Abuse:_____
Depressive Symptoms:
Weight Change_____Sleep Disturbance_____Psychomotor Slowing_____
Loss of energy_____Crying Spells_____Suicidal thoughts_____Feelings of
Wothlessness_____Social Withdrawal_____Loss of Interest_____
Poor Concentration_____Inappropriate Guilt_____Fatique_____
Agitation_____Indecisiveness_____

Anxiety:
Muscle Aches_____Abdominal Distress_____Choking_____Dry Mouth_____
Frequent Urination_____Swallowing Problems_____Sweating_____
Restlessness_____Trembling_____Panic_____On Edge_____Keyed Up____
Irritability_____Tachycardia_____Fatigue_____Flushes_____Chills_____
Dizzyness_____Fainting_____Distress_____Concentration_____
Current Level of functioning(Behavioral Symptoms):
Sleep (regularity, quality, insomnia, late nights, nightmares, dreams):_____
_____
Eating(anorexic, bulemic, picky, overeating, weight problems):_____
_____
School/Work (when started, reliability, consistency, avoidance):_____
_____
Relationships (Peers, best friends, enemies, romances, stability,supportiveness):____
_____
_____

Health:
Exercise:_____
Injuries:_____
Chronic problems:_____
Hygiene:_____

Previous Coping to stress and provocation (Include Clients Strengths and resources):

_____

_____

_____

_____

Most recent Medical Exam or Physical:_____

Physican:_____

Illegal or Risky Behaviors:

Arrests: Y/N Year?Charge/Time Incarcerated/Probation

_____

History of Violence/Abusive Behaviors:Y/N

What?_____

Do you or your partner have an explosive temper: Y/N

Have you(or partner) ever hit, shoved, choked, kicked a significant other : Y/N

Have you(or partner) ever thrown or broken things when angry? Y/N

Comments:_____

Exposure to:

Violence:_____

Gang activities:_____

Past Child Abuse:_____

_____

Moving history:_____

Significant Events/Losses:_____

_____

Trauma:_____

_____

Family Myths:_____

Teen pregnancies:_____

Living arrangements:_____

Health (family diseases, traumas, psychiatric):_____

_____

Deaths(effect on client):_____

_____

Limit Setting (Mother, father, others, methods, frequency, consistency, restrictiveness):

_____

_____

Nurturing(father, mother. modes of demonstration, clients attitude):_____

Family Education(Father, mother, siblings, attitudes toward, help with homework):_____

_____

_____

Other comments:_____

_____

_____

_____

_____

_____

_____