fromwithin COUNSELING

James Kelleher, MA, LPC, NCC
Psychotherapist

CLIENT INTAKE

Please take a few minutes to complete the information in this packet. The answers you provide will help me to gain a better perspective of your needs and how best to address the concerns in your life. All information provided is strictly confidential.

DATE OF INITIAL VISIT ___/____/____

HOW DID YOU HEAR ABOUT US? (please check box)

☐Google/Internet search ☐PsychologyToday.com ☐Insurance company listing: Ins Co. Name:_____
☐Advertisement: Where:_____ ☐Referred by family/friend/doctor: Who:_____
☐Other _____

PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)
Birth Date: ___/____/____ Age: _____
Address: _____
(Number & Street) (City, State) (Zip Code)

Mobile # (_____) _____ May we leave a message? ☐Yes ☐No
Home # (_____) _____ May we leave a message? ☐Yes ☐No
Email Address: _____@_____

EMERGENCY CONTACT

_____ (_____)_____ _____
Name Phone Relationship to You

ROMANTIC/SEXUAL ORIENTATION

☐ Heterosexual/Straight ☐ Gay/Lesbian ☐ Bisexual
☐ Questioning ☐ Transgender

RELATIONSHIP STATUS

☐ Never Married ☐ Partnered ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Name of Significant Other (if any): _____ How Long Have Both of You Been Together? _____
On a scale of 1-10 (1 being poor), how do you rate the quality of your relationship? _____
Number of Children (if any): _____

EDUCATION/EMPLOYMENT HISTORY

Beginning with 9th grade, years of education completed: _____

Current employment/career: _____

HEALTH HISTORY

Rate your physical health at present: (Check Box)

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very good

Relevant medical conditions (history, current condition, changes in condition):

_____
_____
_____
_____

Current Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____
_____
_____
_____
_____
_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐ Yes ☐ No

If yes, with whom: _____

Have you ever had previous psychotherapy? ☐ Yes ☐ No

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ Yes ☐ No

If yes, what is your faith? _____

If no, do you consider yourself spiritual? ☐ Yes ☐ No

SYMPTOM CHECKLIST

Below, you will find a list of symptoms. While many may not apply to you, it is important to carefully review each and rate them as they relate to you currently. Remember that most of us feel some of these symptoms on a day to day basis. Honest answers will help guide your therapy and are important to your success.

Emotional Concerns	Mild	Moderate	Severe	N/A
Feeling anxious or uptight	☐	☐	☐	☐
Excessive worrying	☐	☐	☐	☐
Not being able to relax	☐	☐	☐	☐
Feeling panicky	☐	☐	☐	☐
Unable to calm yourself down	☐	☐	☐	☐
Dwelling on certain thoughts or images	☐	☐	☐	☐
Having strong fears	☐	☐	☐	☐
Worrying about a nervous breakdown	☐	☐	☐	☐
Feeling out of control	☐	☐	☐	☐
Avoiding being with people	☐	☐	☐	☐
Fears of being alone or abandoned	☐	☐	☐	☐
Feeling guilty	☐	☐	☐	☐
Having nightmares	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐
Troubling or painful memories	☐	☐	☐	☐
Trouble remembering things	☐	☐	☐	☐
Feeling numb instead of upset	☐	☐	☐	☐
Depressed or sad	☐	☐	☐	☐
Being tired or lacking energy	☐	☐	☐	☐
Feeling unmotivated	☐	☐	☐	☐
Loss of interest in many things	☐	☐	☐	☐
Having trouble concentrating	☐	☐	☐	☐
Having trouble making decisions	☐	☐	☐	☐
Feeling the future looks hopeless	☐	☐	☐	☐
Feeling worthless or a failure	☐	☐	☐	☐
Being unhappy all the time	☐	☐	☐	☐
Dissatisfied with physical appearance	☐	☐	☐	☐
Feeling self critical or blaming yourself	☐	☐	☐	☐
Having negative thoughts	☐	☐	☐	☐
Crying often	☐	☐	☐	☐
Feeling empty	☐	☐	☐	☐
Withdrawing inside yourself	☐	☐	☐	☐
Thinking too much about death	☐	☐	☐	☐
Thoughts of hurting yourself	☐	☐	☐	☐
Thoughts of killing yourself	☐	☐	☐	☐
Frequent mood swings	☐	☐	☐	☐
Feeling resentful or angry	☐	☐	☐	☐

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Below, you will find a list of symptoms. While many may not apply to you, it is important to carefully review each and rate them as they relate to you currently. Remember that most of us feel some of these symptoms on a day to day basis. Honest answers will help guide your therapy and are important to your success.

Behavioral and Physical Concerns	Mild	Moderate	Severe	N/A
Not having an appetite	☐	☐	☐	☐
Eating in binges	☐	☐	☐	☐
Self-induced vomiting for weight control	☐	☐	☐	☐
Using laxatives for weight control	☐	☐	☐	☐
Eating too much	☐	☐	☐	☐
Eating too little	☐	☐	☐	☐
Losing weight if so, how much?	☐	☐	☐	☐
Gaining weight if so, how much?	☐	☐	☐	☐
Trouble sleeping	☐	☐	☐	☐
Trouble falling asleep	☐	☐	☐	☐
Early morning awakening	☐	☐	☐	☐
Sleeping too much	☐	☐	☐	☐
Sleeping too little # of hours I usually sleep:	☐	☐	☐	☐
Lack of exercise	☐	☐	☐	☐
Not having leisure activities	☐	☐	☐	☐
Smoking cigarettes	☐	☐	☐	☐
Often spending in binges	☐	☐	☐	☐
Temper outbursts	☐	☐	☐	☐
Aggressive toward others	☐	☐	☐	☐
Impulsive reactions	☐	☐	☐	☐
Trouble finishing things	☐	☐	☐	☐
Working too hard	☐	☐	☐	☐
Using alcohol too much	☐	☐	☐	☐
Using drugs	☐	☐	☐	☐
Blackouts—after drinking	☐	☐	☐	☐
Frequent mood swings	☐	☐	☐	☐
Feeling resentful or angry	☐	☐	☐	☐

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Sexual Concerns	Mild	Moderate	Severe	N/A
Too tired to have sex	☐	☐	☐	☐
Too anxious to have sex	☐	☐	☐	☐
Feeling a lack of sexual desire	☐	☐	☐	☐
Wanting to have sex more often	☐	☐	☐	☐
Feeling neglected sexually	☐	☐	☐	☐
Feeling used sexually	☐	☐	☐	☐
Feeling unable to have orgasm	☐	☐	☐	☐
Being unable to sustain an erection	☐	☐	☐	☐
Feeling negatively about sex	☐	☐	☐	☐

Intimate Relationship Concerns	Mild	Moderate	Severe	N/A
Problems with dividing household tasks	☐	☐	☐	☐
Disagreeing about children	☐	☐	☐	☐
Lack of affection	☐	☐	☐	☐
Unsatisfactory sexual relationship	☐	☐	☐	☐
Lack of time together	☐	☐	☐	☐
Lack of shared interests	☐	☐	☐	☐
Lack of time with other couples	☐	☐	☐	☐
Jealousy in relationship	☐	☐	☐	☐
Frequent arguments	☐	☐	☐	☐
Trouble resolving conflict	☐	☐	☐	☐
Partner being demanding and controlling	☐	☐	☐	☐
Partner putting you down	☐	☐	☐	☐
Violent arguments	☐	☐	☐	☐
Emotional abuse in relationship	☐	☐	☐	☐
Physical abuse in relationship	☐	☐	☐	☐
Sexual abuse in relationship	☐	☐	☐	☐
Partner having alcohol or drug problem	☐	☐	☐	☐
Self or partner having an affair	☐	☐	☐	☐
Feeling uncommitted to relationship	☐	☐	☐	☐
Wanting to separate	☐	☐	☐	☐
Discussing separating or divorce	☐	☐	☐	☐
Problems with in-laws	☐	☐	☐	☐
Problems with ex-partner	☐	☐	☐	☐
Children having special problems	☐	☐	☐	☐

Have You Ever...

been physically abused	☐ Yes ☐ No	if yes, by whom?	_____
been emotionally abused	☐ Yes ☐ No	if yes, by whom?	_____
been sexually abused	☐ Yes ☐ No	if yes, by whom?	_____
had an alcoholic parent	☐ Yes ☐ No	if yes, which one?	_____
had a drug abusing parent	☐ Yes ☐ No	if yes, which one?	_____
had a depressed parent	☐ Yes ☐ No	if yes, which one?	_____
had a parent with emotional problems	☐ Yes ☐ No		
had parents separate or divorce	☐ Yes ☐ No		
experienced the death of a close family member or friend	☐ Yes ☐ No	if yes, by whom?	_____
felt neglected or unloved	☐ Yes ☐ No	if yes, by whom?	_____
had an unhappy childhood	☐ Yes ☐ No		
had drug or alcohol problem	☐ Yes ☐ No		
frequently moved	☐ Yes ☐ No		
had learning problems	☐ Yes ☐ No	if yes, what?	_____
attempted suicide	☐ Yes ☐ No	if yes, when?	_____

Stresses During the Past Several Years:

experienced the death of a close family member or friend	☐ Yes ☐ No	if yes, whom?	_____
had a birth or adoption of child	☐ Yes ☐ No		
hospitalization of yourself or a loved one	☐ Yes ☐ No	if yes, whom?	_____
moved	☐ Yes ☐ No		
been harassed or assaulted	☐ Yes ☐ No		
had frequent family or couple arguments	☐ Yes ☐ No	if yes, with whom?	_____
experienced separation/divorce	☐ Yes ☐ No	if yes, by whom?	_____
lost or changed your job	☐ Yes ☐ No		
had financial trouble	☐ Yes ☐ No		
had legal problems	☐ Yes ☐ No		
had serious or chronic illness	☐ Yes ☐ No	if yes, what?	_____
other	☐ Yes ☐ No	if yes, what?	

What are the primary stressors in your life:

1._____

2._____

3. _____

What are your goals for therapy:

1. _____

2. _____

3. _____

Any additional concerns:

_____

_____

_____

Client Signature_____Date_____