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COUNSELING SERVICES
INTAKE FORM

PERSONAL INFORMATION

Name: ____
(Last) (First) (Middle Initial)

Address: ____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) ______________ May we leave a message? ☐Yes ☐No

Cell or Other Phone: ( ) ___________ May we leave a message? ☐Yes ☐No

E-mail Address: ____________________ __________

Birth Date: ______ /______ /______ Age: ________ Gender: ☐Male ☐ Female ☐Other (specify_____________)

Marital Status: ☐ Never Married ☐Partnered ☐Married ☐ Separated ☐ Divorced ☐ Widowed

Partner's Name & Length of Relationship:______________________________

Children (Names/Ages):______________________________

Emergency Contact Name/ Relationship: ____________________Phone:____________________

Currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ☐Yes ☐No

Currently taking prescribed psychiatric medication (antidepressants or others)? ☐Yes ☐No

Previously prescribed psychiatric medication? ☐Yes ☐No

OCCUPATIONAL HISTORY

Currently employed? ☐Yes ☐No Employer& Job Title/Description______________________________

Work-related stressors, if any:______________________________

Previous jobs & number of years spent at those jobs:______________________________

Prefer working independently or in groups?______________________________

LEGAL HISTORY

Ever been arrested? ☐Yes ☐No If so, why?______________________________

Ever been involved in any legal action or court case? ☐Yes ☐No

If yes, explain:______________________________

FINANCIAL HISTORY

Ever experienced problems with:

Poverty Money Management Bankruptcy

ACADEMIC BACKGROUND

____

CULTURAL BACKGROUND

Ethnic identity? ______________Cultural Identification (circle one): Not at all Somewhat Moderately Strongly

Religious preference:____________________Currently active in religion? Yes ☐ Somewhat ☐ No ☐

MILITARY BACKGROUND

Did you serve in the military? _______ What branch did you serve in? __________ What was your MOS? ____________________

What was your *best day* in your military service?______________________________

What was your *worst day* in your military service?______________________________

How strongly do you identify with the military culture now?______________________________

FAMILY BACKGROUND

1. Members of current family, including ages and occupations:

____

2. Check any past, present, or impending special problems in family:

- ❑ Deaths
- ❑ Divorce
- ❑ Frequent Relocations
- ❑ Debilitating Injuries/Disabilities
- ❑ Alcohol/Drug Abuse
- ❑ Serious Illness
- ❑ Psychiatric Disorder
- ❑ Physical/Sexual Abuse
- ❑ Financial Crisis/Unemployment
- ❑ Legal Problems
- ❑ Attempted/Completed Suicide
- ❑ Eating Disorders
- ❑ Other

Specify family member(s), which special problem, and approximate year of occurrence

____

Experienced significant family abuse?

None Unsure Emotional Physical Sexual

Experience learning problems in elementary or high school? (Circle one):

None Little Some Substantial Lots, constant struggle

How much is immediate family a source of emotional support? (Circle one):

None Little Somewhat Substantial Very Strong

How much conflict in values currently experienced with parents? (Circle one):

Very little or none Some Moderate Strong Extreme

Who in family does client feel closest to? ___________________________________

Most distant from?______________________ In most conflict with? _____________________

SOCIAL HISTORY

Quality of peer relationships?

Very Poor Unsatisfactory About Average Good Excellent

Approximate number of significant intimate relationships (lasting 6 months or more) : _______________

In one now? Yes No I think so

On a scale of 1-10, how would client rate the quality of current relationship?____________

Previous significant relationships and durations:

____

Besides family members, approximate number of people client can count on right now for friendship or emotional support? _______________

To whom was client closest as a child? ____

Did client have a mentor or mentors as a child (e.g., parent, teacher, coach, friend's parent, etc.)?_____________________

MENTAL HEALTH HISTORY

Ever been in counseling? ____

If so, when, and for how long?_ ____

If so, why?____________________________ _______________________________________

____

If so, what did you find helpful? ____ _________________________________

What did you find disappointing, or unhelpful?____

SUBSTANCE USE HISTORY

	Alcohol	Marijuana	Amphetamines	Cocaine (Crack)	Hallucinogens	Inhalants	Heroin	Other Narcotics	Prescription Medications	OTC Medications
Date of Most Recent Use										
Estimated # of Days in Last Month										
Estimated # of Years in Lifetime										
Age First Used										
Age Used Regularly										

Regularly use alcohol? Yes No
In a typical month, how often does client have 4 or more drinks in a 24 hour period? __________
Is alcohol consumption a problem? Yes No Unsure
How often does client engage in recreational drug use? Daily Weekly Monthly Rarely Never
Is drug use a problem? Yes No Unsure

CURRENT PATTERN OF DRUG/ALCOHOL USAGE
(Drug of choice, situation used, desired effect, how much, how often; recognition of impairment, craving, dependence, withdrawal symptoms, sober periods; previous attempts to stop; treatment and response;):
____
____

HEALTH AND SOCIAL ISSUES
Physical health at present? Poor Unsatisfactory Satisfactory Good Very good
Persistent physical symptoms or health concerns:
____
Presently taking any prescribed medication? No Yes
____
Having any problems with sleep habits? No Yes
Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other
How many times per week does client exercise? __________ For about how long each time? ___________
Having any difficulty with appetite or eating habits? No Yes
Eating less Eating more Binging Restricting
Significant weight change (last 2 months) ____
Have any problems or worries about sexual functioning? No Yes
Lack of desire Performance Problem Sexual Impulsiveness Difficulties maintaining arousal
Ever experienced sexual assault, unwanted sex or uncomfortable touching?
Frequently A few times Once Never Unsure
Had suicidal thoughts recently? Frequently Sometimes Rarely Never
Had them in the past? Frequently Sometimes Rarely Never
Ever intentionally inflicted any harm upon self? Yes No Unsure

SEXUAL HISTORY
Any history of past or current sexual dysfunction? ____
Any history with infertility and/or miscarriages?______________________________+________________
Any history with STDs?____
Any concerns about sexual orientation? ____
Where does client fall on Kinsey Scale:

0 = exclusively heterosexual
1 = predominantly heterosexual, incidentally homosexual
2 = predominantly heterosexual, but more than incidentally homosexual
3 = equally heterosexual and homosexual
4 = predominantly homosexual, but more than incidentally heterosexual
5 = predominantly homosexual, incidentally heterosexual
6 = exclusively homosexual

TRAUMA HISTORY

Client has experienced:

Event:		Age at time (best estimate):
A physical assault	yes/no	
Verbal abuse	yes/no	
Emotional abuse	yes/no	
A sexual assault	yes/no	
Molestation	yes/no	
Unwanted sexual attention	yes/no	
Sexual harassment	yes/no	
Gender discrimination	yes/no	
A hate crime	yes/no	
Other trauma	yes/no	

FAMILY MENTAL HEALTH HISTORY

Difficulty		Family Member (Please indicate whom/when)
Depression	yes/no	yes/no
Bipolar Disorder	yes/no	yes/no
Anxiety Disorders	yes/no	yes/no
Panic Attacks	yes/no	yes/no
Schizophrenia	yes/no	yes/no
Alcohol/Substance Abuse	yes/no	yes/no
Eating Disorders	yes/no	yes/no
Learning Disabilities	yes/no	yes/no
Trauma History	yes/no	yes/no
Suicide Attempts	yes/no	yes/no

Has client ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

What do you consider to be your strengths?

____

____

What do you like most about yourself?

____

____

What are effective coping strategies that you have learned?

____

____

What counseling goals do your have in mind?

____

PRESENTING PROBLEM

1. PROBLEM DESCRIPTION:

____

2. PROBLEM INTENSITY:

1	2	3	4	5
Not Intense		Moderately Intense		Extremely Intense

3. PROBLEM DURATION:

____

4. COPING ATTEMPTS:

____

Looking back over the last week, including today, which response best describes client's current situation.

Never *Rarely* *Sometimes* *Frequently* *Almost Always*

1. I get along well with others. _______________
2. I tire quickly. _______________
3. I feel no interest in things. _______________
4. I feel stressed at work/school. _______________
5. I blame myself for things. _______________
6. I feel irritated. _______________
7. I feel unhappy in my marriage/significant relationship. _______________
8. I have thoughts of ending my life. _______________
9. I feel weak. _______________
10. I feel fearful. _______________
11. After heavy drinking, I need a drink the next morning to get going. _______________
12. I find my work/school satisfying. _______________
13. I am a happy person. _______________
14. I work/study too much. _______________
15. I feel worthless. _______________
16. I am concerned about family troubles. _______________
17. I have an unfulfilling sex life. _______________
18. I feel lonely. _______________
19. I have frequent arguments. _______________
20. I feel loved and wanted. _______________
21. I enjoy my spare time. _______________
22. I have difficulty concentrating. _______________
23. I feel hopeless about the future. _______________
24. I like myself. _______________
25. Disturbing thoughts come into my mind that I cannot get rid of. _______________
26. I feel annoyed by people who criticize my drinking (or drug use). _______________
27. I have an upset stomach. _______________
28. I am not working/studying as well as I used to. _______________
29. My heart pounds too much. _______________
30. I have trouble getting along with friends _______________
31. I am satisfied with my life. _______________
32. I have trouble at work/school because of drinking or drug use. _______________
33. I feel that something bad is going to happen. _______________
34. I have sore muscles. _______________
35. I feel afraid of open spaces, or driving, or being on buses, subways, and so forth. _______________
36. I feel nervous. _______________
37. I feel my love relationships are full and complete. _______________
38. I feel that I am not doing well at work/school. _______________
39. I have too many disagreements at work/school. _______________
40. I feel something is wrong with my mind. _______________
41. I have trouble falling asleep or staying asleep. _______________
42. I feel blue. _______________
43. I am satisfied with my relationships with others. _______________
44. I feel angry enough at work/school to do something I may regret. _______________
45. I have headaches. _______________

Which of the above concerns are *most* important to client today?

Most important: __________ Second most: __________ Third most: __________