# Lori Sherer, M.A., LMFT, LAADC
Marriage & Family Therapist
Individual, Couple and Family Psychotherapy
Licensed Addictions Treatment Counselor

*License MFC# 52336*
*LAADC#LR01960316*

**mft@san.rr.com**
**www.therapist-sandiego.com** **(858) 531-8305**


**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

Current 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/Spiritual preference:_____Currently active in religious/spiritual practice? 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, as well as family of origin members:

_____

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?_____
*Sexual Orientation/Identity:*
Bisexual
Gay
Heterosexual/Straight
Lesbian
Queer
Other "please feel free to explain" _____
Not Sure
Don't Know

***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 are your hobbies?

_____

What do you consider to be your strengths?

_____

_____

What do you like most about yourself?

_____

_____

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: _____