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BIOPSYCHOSOCIAL INTAKE FORM

Client's Name _____ Age_____

Date of Birth _____ Gender ☐ M ☐ F ☐ Other _____ Pronoun _____

Allergies_____ Date First Seen _____

Home Phone _____ Work Phone _____ Message: ☐ Y ☐ N

Address _____City_____ Zip_____

Emergency Contact: Name _____ Phone _____

(Please use the back side of this form if you need more space to respond to any of the questions)

PRESENTING PROBLEM AND PREVIOUS THERAPY

What is the primary concern or problem for which you are seeking help? Referred by?

_____

_____

_____

_____

_____

What makes it better? What makes it worse?

_____

_____

_____

_____

_____

Are there any ***immediate*** challenges or issues that need our attention? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

_____

_____

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

From when to when? _____ With whom? _____

_____

_____

What was your experience of therapy? (What was your previous therapy like?)

_____

_____

What was most helpful about your therapy?

_____

_____

What was least helpful about your therapy?

_____

_____

What did you learn about yourself through your previous therapy?

_____

_____

What do you expect from me and our work together?

_____

_____

EXPERIENCE: INDIVIDUAL-INTRINSIC

What are your strengths?

_____

_____

_____

What are your weaknesses?

_____

_____

_____

How would you describe your general mood/feelings for the past two weeks?

_____

_____

What emotions do you most often feel most strongly?

_____

_____

What are the ways in which you care for and comfort your self when you feel distressed?

_____

_____

How do you deal with strong emotions in yourself?

_____

_____

_____

_____

How do you respond to stressful situations and other problems?

_____

_____

_____

How do you make decisions (for example, do you use logic and reason, or do you trust your gut and heart)?

_____

_____

_____

Are you aware of recurring images or thoughts (either while awake or in dreams)? □ Yes □ No. If yes, please describe.

_____

_____

_____

Have you *ever* attempted to seriously harm or kill yourself or anyone else? □ Yes □ No. If yes, please describe.

_____

_____

_____

Are you *presently* experiencing suicidal or homicidal thoughts? □ Yes □ No. If yes, please describe.

_____

_____

_____

Has anyone in your family ever attempted or died by suicide? □ Yes □ No. If yes, please describe.

_____

_____

_____

Have there been any serious illnesses, births, deaths, or other losses or changes in your family that have affected you? □ Yes □ No. If yes, please describe.

_____

_____

_____

Have you ever been hospitalized for mental of emotional problems? (For example: nervous breakdown, depression, suicide ideation, mania, schizophrenia, anxiety, drug or alcohol problems, etc). □ Yes □ No. If yes, please describe.

_____

_____

What is your earliest memory?

_____

_____

_____

What is your happiest memory?

_____

_____

_____

What is your most painful memory?

_____

_____

_____

Where in your body do you feel stress (shoulders, back, jaw. etc.)?

_____

_____

Do you have ways in which you express yourself creatively and/or artistically? □ Yes □ No. If yes, please describe.

_____

_____

Describe your leisure time (hobbies/enjoyment).

_____

_____

_____

Have you ever been a victim of, or witnessed, verbal, emotional, physical, and/or sexual abuse? □ Yes □ No. If yes, please describe.

_____

_____

_____

In general, how satisfied are you with your life?

Not at all 1 2 3 4 5 6 7 Very good

In general, how do you feel about yourself (self-esteem)?

Very bad 1 2 3 4 5 6 7 Very good

In general, how much control do you feel you have over your life and how you feel?

None at all 1 2 3 4 5 6 7 A lot

Please mark any of the following feelings or expressions you're having, or have had sometime in the past two to four weeks:

_____ angry _____ difficulty concentrating

_____ sad _____ little interest or pleasure in doing things

_____ lonely
_____ afraid
_____ anxious/worried
_____ shameful/guilty
_____ jealous
_____ happy
_____ grateful/thankful
_____ sexual/erotic
_____ excited
_____ high energy
_____ hopeful
_____ relaxed/peaceful
_____ other emotions you often feel:

_____ poor or excessive appetite
_____ excessive tiredness
_____ feeling ☐ helpless ☐ hopeless or ☐ worthless
_____ having much more energy than normal
_____ thoughts racing through your head
_____ desire to harm yourself
_____ desire to harm someone else
_____ hearing or seeing things not actually there
_____ thoughts that seem strange but that you can't seem to stop
_____ fear that someone is trying to harm you

_____

_____

BEHAVIOR: INDIVIDUAL-EXTRINSIC

Please list any medications you are presently taking (dosage/amount and what the medication is for). Do you take over-the-counter medications, vitamins and other nutritional or herbal supplements? ☐ Yes ☐ No. If yes please list them here also.

_____

_____

_____

_____

_____

_____

Do you have a primary care physician? ☐ Yes ☐ No.

If yes, name: _____ Telephone number: _____

Height _____ Weight _____ lbs. When was your last physical exam? _____

Were there any noteworthy results (diseases, blood pressure, cholesterol, etc.)?

_____

_____

_____

Have you ever suffered a head injury or other serious injury? □ Yes □ No. If yes, please describe.

_____

_____

_____

What other significant medical problems have you experienced or are you experiencing now?

_____

_____

_____

Please mark any of the following behaviors that are true of you:

_____ drink too much
_____ use illegal and/or mind-altering drugs
_____ eat too much
_____ eat too little
_____ neglect friends and family
_____ neglect self and your own needs
_____ difficulty being kind and loving to yourself
_____ act in ways that end up hurting yourself or others
_____ lose your temper
_____ seem to not have control over certain behaviors
_____ think about suicide
_____ have difficulty concentrating/focusing
_____ spend more money than you can afford to
_____ crying spells
_____ sleep too much
_____ sleep too little
_____ get arrested for DUI
_____ spend time in jail
_____ on probation
_____ think that someone wants to harm you
_____ have no interest in life
_____ think about homicide
_____ purge after eating
_____ make impulsive choices
_____ unprovoked anger/rage

_____ any other behaviors you would like me to know about?

_____

_____

Please mark any of the following bodily feelings that are true of you:

_____ headaches
_____ menstrual problems
_____ dizziness
_____ heart tremors
_____ jitters
_____ sexual preoccupations
_____ tingling/numbness
_____ chills/hot flashes
_____ hear or see things not actually there
_____ blackouts
_____ fatigue/fainting
_____ nauseau
_____ choking sensations
_____ vision changes
_____ shortness of breath
_____ tics/twitches
_____ skin problems
_____ chest pains
_____ muscle/joint pain
_____ stomach aches

_____ Do you have any other bodily pains or difficulties? □ Yes □ No. If yes, what are they? _____

_____

In general, how would you rate your physical health?

Very unhealthy 1 2 3 4 5 6 7 Very healthy

Describe your current sleeping patterns. (When do you sleep? How many hours per 24 hours? Do you sleep straight through or do you wake up during sleep time? Do you have trouble falling asleep or staying asleep?).

_____

_____

_____

Do you feel rested upon waking? □ Yes □ No. _____

Describe your usual eating habits (types of food, and how much).

_____

Describe your drug and alcohol use (both past and present).

Do you engage in some form of exercise (aerobic and/or strength building)? □ Yes □ No.

If yes, please describe. _____

Do you have any communication impairments (sight, hearing, speech)? □ Yes □ No If yes, please describe.

CULTURE: COLLECTIVE - INTRINSIC

Describe your relationships, including friends, family, and coworkers.

What is important and meaningful to you (what matters the most to you)?

In general, how satisfied are you with the support you receive from your family/friends?

Not at all 1 2 3 4 5 6 7 Very Satisfied

How satisfied are you with your friendships and other relationships?

Not at all 1 2 3 4 5 6 7 Very Satisfied

In general, how comfortable are you in social situations?

Not at all 1 2 3 4 5 6 7 Very Comfortable

In general, how satisfied are you with your religion/spirituality?

Not at all 1 2 3 4 5 6 7 Very Satisfied

How satisfied are you with your quality of life?

Not at all 1 2 3 4 5 6 7 Very Satisfied

Which emotions were encouraged or commonly expressed in your ***family of origin*** (family you grew up with)?

Which emotions were discouraged or not allowed in your ***family of origin***?

What emotions are most comfortable for you now?

What emotions are most uncomfortable for you now?

How do you identify yourself ethnically? How important is your ethnic culture to you?

_____

How did your ***family of origin*** express love and care?

_____

_____

How does your ***current family*** express love and care?

_____

_____

How did your ***family of origin*** express disapproval?

_____

_____

How does your ***current family*** express disapproval?

_____

_____

How satisfied are you with your current family life?

Not at all 1 2 3 4 5 6 7 Very Satisfied

Describe your romantic/love relationships, if any.

_____

_____

_____

Describe your sex life. How satisfied are you with your sex life?

_____

_____

What beliefs do you have about sex? How important to you are those beliefs?

_____

_____

Do you have a religious/spiritual affiliation and/or practice? □ Yes □ No. If yes, please describe. _____

_____

_____

What beliefs do you have about religion/spirituality? How important to you are those beliefs? What role do they play in your life? Do they inform your decision-making?

_____

_____

What are some of your most important morals and values? How important to you are those morals and values to you?

_____

_____

_____

Describe any community, political or civic involvement in which you participate.

_____

_____

Describe any environmental activities in which you participate (recycling, conserving, carpooling, etc.).

_____

_____

Are you involved with any cultural activities or institutions? □ Yes □ No. If yes, please describe.

_____

_____

Have you ever been a victim of any form of prejudice or discrimination (racial, gender, LGBTQIA+, socioeconomic status, etc.) or felt that you were disadvantaged in terms of power and privilege in society? □ Yes □ No. If yes, please describe.

_____

_____

_____

SOCIAL SYSTEMS: COLLECTIVE - EXTRINSIC

Describe your current *physical* home environment. For example, describe the layout of your home, and other general conditions, such as, privacy, is it well-lit, do you have water, A/C, heating, etc.?

_____

_____

_____