

COUNSELING INTAKE FORM - C

Name _____ Age _____ Date _____

Full Address _____

Home Phone _____ Parent's Work Phone _____

Parent's E-mail _____ Parent's Cell Phone _____

School _____ Grade Level _____

Family member to notify in case of emergency:

Name: _____

Address: _____

Phone: _____

Physical and Mental Health History

General Health _____

Are you now under a doctor's care for injury or illness? _____
If yes, name of doctor _____

Reason for doctor's care _____

Are you taking any medication? _____ If yes, what kind? _____

Reason for medication _____ Last medical examination _____

Have you ever been hospitalized for a physical illness? _____

If yes, what was the reason? _____

Any recent major illnesses or surgeries? _____

Any recurrent or long-term conditions? _____

Have you or any of your immediate family members been diagnosed with mental illness? Which one(s)?

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Any Previous Therapy/Counseling? _____ If yes, when, where, how long, and for what? _____

Have you ever been hospitalized for a mental illness? _____

If yes, what was the reason? _____

Are you currently under the care of another counselor/therapist? _____

If yes, which one? _____

Family Systems Information

Where were you born? _____ How long did you live there? _____

What is your ethnic identity? _____

What is your gender identity? _____

Is your father alive? _____ Where does your father live? _____

Describe your relationship. _____

Is your mother alive? _____ Where does your mother live? _____

Describe your relationship. _____

Are you adopted? _____

If reared by someone other than your birth parents, describe the situation in some detail.

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FAMILY OF ORIGIN MEMBERS

<u>Relationship</u>	<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Last Level of School Completed</u>	<u>Occupation if out of School</u>
Father					
Mother					

Family of Origin Alcoholism or Domestic Violence? _____

Family of Origin Sexual Addictions or Abuse? _____

Parents divorced? _____ If yes, what year? _____ Your age at the time _____

If parents deceased, what year? _____ Your age at the time? _____ Cause of death _____

If siblings deceased, what year? _____ Your age at the time? _____ Cause of death _____

Any step-parents? _____ If yes, describe when and your relationship with them _____

Spiritual History

Childhood religion _____	Present religion _____
Is this an important part of your life? _____	Why/Why not? _____

Emotional Status

Are you currently experiencing stress? _____ If yes, please describe below:

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Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0 (No Concern)	1	2	3	4
5 (Moderate Concern)	6	7	8	
9	10 (Extreme Concern)			

- | | |
|--|------------------------------------|
| _____ Anger | _____ Body Privacy/Private Areas |
| _____ Depression | _____ Thoughts of hurting yourself |
| _____ Education | _____ Tired all of the time |
| _____ Eating difficulties | _____ Trouble making decisions |
| _____ Fearfulness | _____ Unhappy most of the time |
| _____ Nervousness | _____ Use of alcohol in family |
| _____ Use of alcohol in family | _____ Use of other drugs in family |
| _____ Physical problems/sickness | _____ Problems with school grades |
| _____ Problems with social relationships | _____ Worry |
| _____ Problems with other children | _____ |
| _____ Problems with parents | |
| Other _____ | |

Are you currently experiencing strong emotions? _____
If yes, describe below:

Did you have any major losses or problems in your childhood? _____ If yes, describe here:

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Have you used an Individualized Education Plan (IEP) at school? _____

If yes, when? _____

Have you talked about your problems with your counselor at school? _____

If yes, when? _____

Have you been treated for emotional disturbances? _____

If yes, when? _____

Have you had any thoughts of hurting yourself or ending your life? _____

If so, when? _____

Do you have any thoughts of hurting yourself or ending your life now? _____

Hobbies and After School Activities

Hobby 1 _____ How long have you done this? _____

Hobby 2 _____ How long have you done this? _____

Hobby 3 _____ How long have you done this? _____

What is your after-school schedule?

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

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Present Situation

Why did you come for counseling/therapy today? _____

How long has this been a problem for you?

What would you like to experience that is different from what you are experiencing now? _____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when?

What do you think helped?

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when?

What made it bad?

Are there other people who play a major role in causing your problems? Yes _____ No _____

Are there people who help you cope with your problems? Yes _____ No _____

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Explain briefly:

Tell anything else in the space below that you think would be helpful for your therapist to know. For example, are you considering a major life change right now?

What do you hope to gain from counseling?

Do you plan to attend counseling with another member of your family? If so, whom?

What weeknights are you available for counseling?

How many weeks can you commit to counseling sessions?
