

COUNSELING INTAKE FORM - B

Name _____ Age _____ Date _____

Full Address _____

Home Phone _____ Work _____ E-mail _____

School _____ Grade Level _____

Job _____ Total Hours Per Week _____

Employed by _____ Phone _____

Family member (non-parent) 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 illness or injury? _____

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 _____

Do you smoke? _____ Do you take drugs? _____ If yes, what kind? _____

Do you drink? _____ How much? _____

Have you ever been hospitalized for a physical illness? _____

If yes, what was the reason? _____

Any recent major illnesses or surgeries? _____

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Any recurrent or chronic conditions? _____

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

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. _____

Marital Status _____ # of Marriages _____

Living with spouse? _____ How long? _____ Spouse's first name _____

Living with a partner? _____ How long? _____ Partner's First Name _____

Children: #1 M F Age _____ #2 M F Age _____ #3 M F Age _____ #4 M F Age _____ #5 M F Age _____

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					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

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 | _____ Religious/Spiritual Concern |
| _____ Depression | _____ Sexual Concerns |
| _____ Education | _____ Thoughts of suicide |
| _____ Eating difficulties | _____ Trouble making decisions |
| _____ Fearfulness | _____ Unhappy most of the time |
| _____ Nervousness | _____ Use of alcohol |
| _____ Financial problems | _____ Use of alcohol in family |
| _____ Marital problems | _____ Use of other drugs |
| _____ Physical problems | _____ Work |
| _____ Problems with social relationships | _____ Worry |
| _____ Problems with children | _____ Problems with parents |
| _____ Other (specify) _____ | |

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

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Do you make decisions based on your emotions? _____
How well does that work for you? _____

Did you have what you would consider to be childhood or other traumas? _____ If yes, describe here: _____

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

Please state why you decided to come for counseling/therapy. _____

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?
