COUNSELING INTAKE FORM - C

Name_____Age_____DOB_____ Intake 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?_____I
f 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?_____

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_____

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)?

_____

_____

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?_____

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

_____
_
_

FAMILY OF ORIGIN MEMBERS

Relationship	Name	Gender	Age	Last Level of School Completed	Occupation if out of School
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:

_____

_____

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

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Body Privacy/Private Areas

_____ Thoughts of hurting yourself

_____ Tired all of the time

_____ Trouble making decisions

_____ Unhappy most of the time

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_____ Nervousness

_____ Use of alcohol in family

_____ Physical problems/sickness

_____ Problems with social relationships

_____ Problems with other children

_____ Problems with parents

_____ Use of alcohol in family

_____ Use of other drugs in family

_____ Problems with school grades

_____ Worry

_____

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:

_____

_

_____

_

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?____

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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	

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 _____ 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?

_____

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_____

_____

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?

_____