COUNSELING INTAKE FORM - B

Name_____Age_____DOB_____Intake 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?_____

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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?_____
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?_____

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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.

_____
_

FAMILY OF ORIGIN MEMBERS

Relationship	Name	Gender	Age	Last Level of School Completed	Occupation if out of School
Father					
Mother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					

Family of Origin Alcoholism or Domestic Violence?_____

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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.

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

_____ Anger

_____ Depression

_____ Education

_____ Eating difficulties

_____ Fearfulness

_____ Nervousness

_____ Financial problems

_____ Marital problems

_____ Physical problems

_____ Problems with social relationships

_____ Problems with children

_____ Other (specify) _____

_____ Religious/Spiritual Concern

_____ Sexual Concerns

_____ Thoughts of suicide

_____ Trouble making decisions

_____ Unhappy most of the time

_____ Use of alcohol

_____ Use of alcohol in family

_____ Use of other drugs

_____ Work

_____ Worry

_____ Problems with parents

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

_____

_____

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

_____

_____

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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	

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 _____ 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?

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_____

_____

_____

How many weeks can you commit to counseling sessions?

_____