COUNSELING INTAKE FORM

Name____Age_________Date__________

Full Address____

____

Home Phone__________________________Work______________________E-mail______________

Work History

Occupation____ How long?______________________

If presently unemployed, describe the situation____

____

Hobbies/Avocations____

Any past/present military service? ____________ Branch? _______________________________________
If you served in combat, when did you serve? ____
Type of discharge? ____
Reason for discharge?____

Education

Last grade completed in school/ highest degree obtained is/was:___________________________________
Are you currently enrolled in school? _________ Major/focus? ____________________________________
Do you have any special training, skills, or certifications? _____________________________________
Do you have any problems reading or writing? ____
How do you learn best? ____
What was school like for you? ____
Describe any difficulties or problems you had/have in
school:____
____
____

Physical History (please be accurate, medical records may need to be disclosed at some point)

General Health____
Are you now under a doctor's care?________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?____Describe__________________________________

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____
Have you ever been hospitalized for a mental illness?____Describe______________________________
____
Any recent major illnesses or surgeries?____
Any recurrent or chronic conditions?____
Do you smoke:________Do you take drugs?________If yes, what kind?___________________________
Do you drink?________How much?____

<u>Chief Concern</u>

Please describe the main difficulty that has brought you to see me:____
____
When did you first start experiencing the problem that brought you to see me? _______________________
____
____
How often does the problem occur? ____
How long does it last? ____
Do you currently have thoughts of harming yourself? □ Yes □ No
Do you currently have thoughts of wishing you were dead? □ Yes □ No
Do you currently have urges to hurt, harm, or kill someone else? □ Yes □ No
If yes, whom? ________________
Have you ever seriously considered suicide or felt like harming someone else? □ Yes □ No
If yes, please explain: ____
____
____

Family Systems Information

Where born______________________________How long there______________Ethnic ID____________
Parents: Father alive?___________Where residing____________________Relationship_______________
Mother alive?________Where residing_________________________Relationship__________________
Marital Status________#of marriages__________________Spouse's name_________________________
Living with a partner_________How long______________Partner's Name_________________________
Children:#1 M F Age_____ #2 M F Age______ #3 M F Age______#4 M F Age_______#5 M F Age_____
Siblings: Circle your place in the family. If a sibling is deceased, put an X through the placement number.
#1 M F Age____ #2 M F Age____ #3M F Age____ #4 M F Age____ #5 M F Age____ #6 M F Age______
Family Alcoholism or Domestic Violence?________________ Sexual Addictions or Abuse? ____________
Family history of mental health issues, even if not diagnosed? ______________________________________
Parents divorced?___________If yes, what year_____________Your age at the time__________________
If deceased, what year?_________Your age at the time__________Cause of death____________________
Any step-parents?________If yes, describe when and your relationship with them____________________
____
If reared by someone other than your birth parents, describe the situation in some detail________________
What family members are you closest to now? ____
____
As you were growing up, what adult(s) stood out as people you could really trust? ______________________
____
Check the statements below that describe the type of family you grew up in:
□ overly close family □ no "breathing room" □ everyone was in everyone else's business
□ no privacy □ boundaries not respected □ comfortably close family □ loving
□ shared many positive experiences □ supportive □ distant, everyone did their own thing
□ not much time spent together □ not a lot of support □ angry, lots of fighting/hostility
□ verbal abuse and conflicts □ violence □ frightening □scared to make mistakes
□ other descriptors ____
Has anyone in your family ever attempted or committed suicide? □ Yes □ No
If yes, please explain: ____

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____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling?
□ Yes □ No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate: ____

When: ____

From Whom: ____

For What: ____

Results: ____

Have you ever taken medications for psychiatric or emotional problems? □ Yes □ No

If yes, please indicate: ____

When: ____

From Whom: ____

For What: ____

Results: ____

Were previous treatment experiences helpful? _________ Why/Why not? ____________________

What do you hope to achieve with therapy with me? _____________________________________

____

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	food binges
guilt	headaches	health problems
hitting/hurting others	inferiority feelings	insomnia
intentional vomiting	internet use/overuse	loneliness
making decisions	marriage	memory
my thoughts	nervousness	nightmares
obsessive thinking	overweight	overspending

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painful thoughts	panic attacks	phobias
relationships	risk taking/endangering others	sadness
self-esteem	separation	sexual problems
short temper	shyness	stealing
sleep	stress	suicidal thoughts
work	yelling/threatening	

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

No Effect	Little Effect	Some effect	Much effect	Strong effect	N/A
Marriage / Relationship:					
Family:					
Job/school performance:					
Friendships:					
Financial situation:					
Physical health:					
Anxiety level / nerves:					
Mood:					
Eating habits:					
Sleeping habits:					
Sexual functioning:					
Alcohol / drug use:					
Ability to concentrate:					
Ability to control anger:					
Recurring/Racing Thoughts					
Current/Past Trauma History					

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Other________					

Spiritual History
Religious upbringing______________________________Present Affiliation_________________
Is this an important part of your life________Why/why not_______________________________

Emotional Status
Are you currently experiencing strong emotions? ____If yes, describe_______________________
____
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
____

Thank you for taking the time to complete this and for your cooperation. I look forward to helping you accomplish the goals and healing that you desire.

Tiffany Harvey, LPC, CCMHC, NCC
Pelorus Counseling and Consulting, LLC

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