Counseling with Care Intake Form

Name _____ DOB _____ Today's Date _____

(Minor) _____ Social Security# _____

Name of person filling out this form other than self and reason: _____

_____
_

Full Address
_____

Cell _____ Home _____ Email _____

OK to leave messages: Yes No If yes, where _____

Is it ok to send you an appointment reminder text or call? Yes No If yes, where _____

Employer _____ Occupation _____

Student (if so) school_____

In Case of Emergency _____ Relationship _____ Phone _____

Referred by _____ May we send them a thank you? Yes No

Problem Assessment

Present Problem - Precipitating Stressors: "In recent months, I have worried a lot about"

Please circle all that apply:

Marital issues Health issues Job issues Financial issues Parent/child issues

Issues of the past (guilt, abuse, neglect, family of origin issues, etc.)

Other _____

Symptoms: *Please circle all that apply:*

Change in sleep pattern	Decreased concentration	Change in appetite
Increased anxiety	Decreased energy	Suicidal feelings
Decreased motivation	Other _____	

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes No

If yes, How? _____

Is there a history of suicide in your nuclear and/or extended family? Yes No
Have you ever inflicted burns or wounds to yourself? Yes No
Are you presently suicidal/homicidal? Yes No

What issues have brought you to seek counseling and what are you hoping to achieve through counseling? _____

When did these problems develop? _____

_____

_____

__

Circle any recent losses you have experienced.

Family Health Disruption of lifestyle Job Significant other

Other _____

List your Strengths and Weaknesses

Strengths	**Weaknesses**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Living Arrangements: _____

Where do you currently live? _____ How long there? _____

With whom do you live? _____

Describe your current relationship with family member's _____

_____

_____

__

Support System:

Who can you count on for support? *Circle as many as apply.*

Parents Spouse Siblings Employer Church Pastor Therapist

Extended family Neighbor(s) Self-help Group Close friend Community Service Co-Worker

Medical Dr. Other _____

Financial Situation:

Describe briefly your financial situation _____

_____

_____

__

Relationship History:

When were you married? _____Name and age of spouse/significant other _____

Previous marriage(s)? Yes No If yes, date of divorce(s) _____

Any children from this marriage/relationship(s)?

_____

What is your perception of your current relationship status?

(Include communication patterns, problems, sexual relations)_____

_____

_____

__

List names and ages of children. How do you get along with each one?

Name	Age	Comment	Bio, Step, Adopted
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Religious/Cultural Factors:

Please list any issues, which are important or may have affected you in regard to religion or ethnic/cultural background. _____

_____

_____

__

What is your religious background? _____

Do you attend religious services? If so, where and how frequent? _____

_____

_

Nutrition:

Have your eating habits changed recently? Yes No If so, please describe _____

_____

_

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes No

Do you often eat out of depression, boredom, and anger? Yes No If yes, please describe

_____

_

_____

_

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them? _____

_____

_

_____

_

Legal History:

Please explain all that apply:

Charges as a minor _____

Charges presently _____

Arrests (how many) _____

Parole/Probation_____

Convictions (how many) _____

Bankruptcy _____

Civil Suits _____

Developmental History:

List members of your family of origin and how you got along with each one.

Family member	**Comment**
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order? # ___ of ___ children who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child? (include friends, school, hobbies, and personality) _____

_____

_____

_____

___

Were there any unusual traumatic experiences for you as a child?

Date	**Age**	**Event**
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

What is your sexual orientation? _____

Psychiatric History

Please list previous outpatient counseling experiences.

Place _____

Length of time there _____ Dates _____

Have you ever been admitted to a hospital for mental health of addiction issues? Yes No

Place _____

Length of time there _____ Dates _____

Name of current doctor and/or therapist _____

List all medications you have taken in the past for anxiety, depression, and/or sleep:

_____

_Would you sign a release of information?

_____

Medical Information:

How would you describe your current health? _____

Are you currently on any medication? Yes No

Name of medication	Dosage/frequency	Prescribing Physician
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Has it been more than a year since your last physical exam including blood test? Yes No
Have you ever had an abortion? Yes No
List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Abuse History:

Describe your current usage or usage within the past year (including alcohol, caffeine and tobacco).

Substance	Amount	Frequency	Age of 1st use	Age regular use started	Last use
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you experienced a recent increase in the use of alcohol and/or other substances? Yes No
Do you see usage as a problem? Yes No If yes, when did it become problematic?

_____

Please describe any previous experience with drugs or alcohol _____

_____

_____

_____

___

Please describe significant family history of substance abuse _____

_____

_____

_____

___

Work Adjustment History:

Describe your current job/career _____

_____

_

What do you like/dislike about your employment/career? Please list

Like	**Dislike**
_____	_____
_____	_____
_____	_____
_____	_____

How do you deal with authority figures? _____

Describe your relationship with co-workers/supervisor/boss _____

_____

_

Have you ever been fired? Yes No If yes, please explain _____

_____

_

Military History:

_____

_

Educational History:

What was school like for you? _____

Highest level achieved _____ What type of grades did you make? _____

Family:

Would it be beneficial for any members of your family to be involved in your treatment?

Yes No If yes, explain who and why _____

_____

_____

__

Additional Information:

Are there any other things that can be helpful for us to know about you? _____

_____

_____

_____

___

I have read and understand my HIPPA rights and consent for treatment. I am responsible for payments and fee's agreed upon between the Counselor and myself. I understand payments are due at the time of service. All appointments must be cancelled within 24hrs notice to avoid being charged a cancellation fee.

_____ _____

Client Signature Date