Individual Intake Form

Date _____

Name _____ Cell Phone _____ Home Phone_____

Occupation _____

Address _____

Birthdate _____ Age _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship to you _____

MEDICAL CONTACT

Name of general practitioner _____ Phone _____

Name of psychiatrist _____ Phone _____

Date last seen by a doctor _____

COUNSELING APPOINTMENT

Why are you seeking counseling at this time?

_____

_____

_____

I know I will be finished with counseling when:

_____

_____

_____

Relationship Status

Married: _____ Single: _____ Divorced: _____

Children: _____

Names and ages: _____

_____

FAMILY HISTORY

Mother's Name: _____

Living ____ Deceased ____ Your age at time of mother's death? _____

Father's Name: _____

Living ____ Deceased ____ Age at time of father's death? _____

Describe current relationship with parents _____

_____

_____

Are parents married? _____ divorced? _____

How old were you when your parents divorced? _____

Stepmother's name _____ Living _____ Deceased _____

Stepfather's name _____ Living _____ Deceased _____

Describe current relationship with stepparents.

_____

_____

Siblings/Stepsiblings

Name Living Deceased

_____

_____

_____

_____

Describe current relationships with siblings/stepsiblings.

_____

_____

_____

CHILDHOOD HISTORY

Provide five adjectives describing your life from birth to end of elementary school.

_____ _____ _____ _____ _____

Provide five adjectives describing your life today.

_____ _____ _____ _____ _____

How were birthdays celebrated in your home? _____

_____

How were you disciplined in your home before age 12? _____

HEALTH HISTORY

How would you rate your current physical health?

(Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

_____

Are you currently taking any medication? _____ If so, what medication/dosage? _____

_____

How would you rate your current sleeping habits?

(Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

_____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

What significant life changes or stressful events have you experienced recently? _____

_____

_____

Mental Health History (in the section below, identify if there is a family history of any of the following. If yes, ***please indicate self or family member's relationship to you*** in the space provided (e.g., father, grandmother, uncle, etc.)

Family Member Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____

Are you currently suicidal? _____ Do you have a plan? _____

What strategies do you use to cope with stress?

_____

_____

Additional Information

Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

What are your hobbies and interests?

_____

_____

Please list 3 relationships who are your primary source of support (i.e., friend, parent, co-worker, spouse)

_____

_____

_____

Do you consider yourself to be spiritual or religious? If yes, please explain.

_____

_____

_____

Is there any other information you would like me to know?

_____

_____

_____