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# COUNSELING INTAKE INFORMATION

Name: ____________________________________________________ Date ___________________

Address: _________________________________________________________________________________

Phone : Home: _________________________ Work: _____________________ Cell :_____________

Age: ___________ Birth date: _______________________ Occupation :________________________________

Employer or school: _________________________________________ Years of formal education: ________

Referred by: ________________________________________________________________________________

Relationships: ____single ____engaged ____married ____separated ____divorced ____widow/er

Persons residing in the same household

| Name | Relationship | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Children: boys _____ ages ___________ girls _____ ages ___________

Children reside with client: yes____ no____ sometimes _____

**Primary care provider (physician, ARNP, PA-C, etc.)**

Name: __________________________________________________ Facility: _____________________________

Address: _____________________________________________________ Phone: ________________________

Last seen: _________________________ Desire for coordinated care ? ____ yes ____no

**Other providers with whom you would like me to coordinate care**

Name: ______________________________________________ Facility: __________________________

Address: ____________________________________________ Phone: ___________________________

**Medications**

| Name | Dosage | Frequency | Start date | Prescribed by | Purpose |
|---|---|---|---|---|---|
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |
| ________________ | ___________ | ___________ | ___________ | _____________ | __________ |

Other medications: ______________________________________________________________________

Have you ever been hospitalized? __________ If yes, when and for what? ____________________________

Overall health assessment (please circle) poor fair good excellent

**Mental health history, counseling history and goals**

How would you describe the issue or problem that brings you to counseling? ___________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

What solutions have you attempted related to your presenting issue(s)? What has been helpful and what has not been helpful?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Please rate the following symptoms according to the number scale below as you experience them now:**

0 = never 1 = rarely 2 = sometimes 3 = often 4 = always

____alcohol/drug abuse ____alcohol/drug abuse of family member or significant other

____compulsive behavior ____depressed mood ____low motivation

____mood swings ____manic episode ____anger outbursts

____irritability ____obsessive thoughts ____diminished pleasure

____diminished sexual interest ____pessimism ____suicidal thoughts

____grief/loss ____poor impulse control ____anxiety: panic

____anxiety: phobic ____anxiety: worry ____guilt thoughts/feeling

____procrastination/avoidance ____impaired attention ____shame

____intrusive thoughts ____relationship problems ____appetite disturbance

____sleep disturbance ____isolation/withdrawl ____self-harm behaviors

____fatigue ____legal problems ____financial problems

____binge-eating ____dieting restricting food ____purging (any means)

____health problems (please specify) ____________________________________________________________

Are there any other experiences you want me to know about?

__________________________________________________________________________________________

__________________________________________________________________________________________

Have you ever received counseling before? _______ If so, when? ________Was it helpful to you? ___________

Please comment on what was/was not helpful _______________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Have you previously received a formal mental health diagnosis (such as depression, bipolar disorder, etc.)?

_____yes ____no If yes, please specify ______________________________________________

______________________________________________________________

**Substance Habits**

Do you currently use: alcohol (yes/no) frequency ___________________________________

cigarettes (yes/no) frequency ___________________________________

caffeine (yes/no) frequency ___________________________________

illegal drugs (yes/no) frequency ___________________________________

Have you ever received treatment for substance abuse? ____yes ____no

Are you concerned about your relationship with any substances? ____yes ____no

Has anyone ever expressed concern about your relationship with substances? ____yes ____no

**Self-harm risk assessment**

How would you rate the risk that you would commit suicide? none low medium high

If you answered other than none, please answer the following by circling all those which apply:

Thoughts only Plan Intent Access to means Previous attempt

Comments (optional): ____________________________________________________________

_______________________________________________________________________________

**Abuse assessment (optional)**

Have you experienced any of the following kinds of abuse? If yes, please indicate by circling type(s):

Physical Emotional Verbal Sexual Neglect

Specify, if you wish (optional) ______________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Support system**

Whom would you consider the supportive people in your life right now? ____________________

_______________________________________________________________________________

**<u>Personal strengths</u>**

Please check the following personal resources you have which help you face life challenges and problems:

| | | | |
|---|---|---|---|
| ____abstract reasoning | ____health habits | ____open, disclosing | ____self-expressive |
| ____confidence | ____housing stability | ____patience | ____self-reliant |
| ____emotionally stable | ____impulse control | ____physical health | ____sense of humor |
| ____empathic | ____insightful | ____positive attitude | ____social skills |
| ____family stability | ____ friends | ____intelligence | ____problem solving |
| ____financial stability | ____reflective | ____social support | ____goal clarity |
| ____work stability | ____motivation | ____resilience | ____work ethic |

Other resources or strengths: ______________________________________________________________________

__________________________________________________________________________________________

**Please write in your own words your goals for our work together, as best you know.**

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Thank you for completing this questionnaire. I look forward to our work together.