Intake Form

Instructions: To assist me in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

Name: _____ Age: _____ Gender: ___M ___F

Address: _____
Street & Number City State Zip

Email address:_____

Today's Date: _____ Date of Birth: _____ Years of education : _____

Occupation: _____ Home Phone: _____ Business Phone:_____
Cell Phone: _____

Present Relationship/Marital Status:
____ never married
____ married ____ # of times married ____ # of years in marriage(s)
____ not married but in a relationship ____ # of months/years
____ not married but live with partner ____ # of months/years
____ single
____ separated
____ divorced
____ widowed

Number of Children: _____
Ages/Names: _____
Military Service: _____

Counseling History

Have you received counseling in the past?: Yes_____ No_____
If Yes, please briefly describe:_____
_____

What is (are) your main reason(s) for this visit?
_____ _____
_____ _____
_____

How long has this problem persisted? _____
_____ _____

Under what conditions do your problems usually get worse? _____

_____

Under what conditions do your problems usually improve?_____
_____

How did you hear about this clinic, or who referred you?_____

Medical History

Name and address of your primary physician:
Physician's name: _____
Address: _____

List any major illnesses and/or operations you have had:
_____
_____

List any physical concerns you are having at present: (e.g., high blood pressure, headaches,

dizziness, etc.):_____

_____

List any other physical concerns you have experienced in the past _____
_____
_____

When was your most recent complete physical exam _____
Results of physical exam: _____
_____

Alternative/Complementary care? _____

On average how many hours of sleep do you get daily _____

Do you have trouble falling asleep at night? __No __Yes If Yes, describe_____
_____

Have you gained/lost over ten pounds in the past year? __Yes __No lbs gained ___ lost ___
If Yes, was the gain/loss on purpose? __Yes __No

Describe your appetite (during the past week):
_____ poor appetite _____ average appetite _____ large appetite

What medications (and dosages) and supplements are you taking at present?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Religious/Spiritual Background

What is your present religious/spiritual affiliation?

_____

How important is religious/spiritual commitment to you?

Unimportant			Average importance			Extremely important
1	2	3	4	5	6	7

Do you desire to have your religious/spiritual beliefs and values incorporated into the therapy?
__Yes __No __Not sure (If Yes, please explain) _____

_____

Family History

Mother's age:_____ If deceased, how old were you when she died? _____
Father's age:_____ If deceased, how old were you when he died? _____
If your parents are separated or divorced, how old were you then? _____
Number of brother(s) _____ Their ages _____
Number of sister(s) _____ Their ages _____
I was child number _____ in a family of _____ children.
Were you adopted or raised with parents other than your natural parents? Yes___ No ___
Briefly describe your relationship with your brothers and/or sisters: _____
_____

Briefly describe your mother (or mother substitute): _____
_____

How did you get along with your mother when you were a child?

_____ poorly _____ average _____ well

How do you get along with your mother now?

_____ poorly _____ average _____ well

Briefly describe your father: _____
_____

How did you get along with your father when you were a child?
_____ poorly _____ average _____ well

How do you get along with your father now?
_____ poorly _____ average _____ well

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

Life is hopeless.	____Never	____Rarely	____Sometimes	____Frequently
I am lonely.	____Never	____Rarely	____Sometimes	____Frequently
No one cares about me.	____Never	____Rarely	____Sometimes	____Frequently
I am a failure.	____Never	____Rarely	____Sometimes	____Frequently
Most people don't like me.	____Never	____Rarely	____Sometimes	____Frequently
I want to die.	____Never	____Rarely	____Sometimes	____Frequently
I want to hurt someone.	____Never	____Rarely	____Sometimes	____Frequently
I am so stupid.	____Never	____Rarely	____Sometimes	____Frequently
I am going crazy.	____Never	____Rarely	____Sometimes	____Frequently
I can't concentrate.	____Never	____Rarely	____Sometimes	____Frequently
I am so depressed.	____Never	____Rarely	____Sometimes	____Frequently
God is disappointed in me.	____Never	____Rarely	____Sometimes	____Frequently
I can't be forgiven.	____Never	____Rarely	____Sometimes	____Frequently
Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
I can't do anything right.	____Never	____Rarely	____Sometimes	____Frequently
People hear my thoughts.	____Never	____Rarely	____Sometimes	____Frequently
I have no emotions.	____Never	____Rarely	____Sometimes	____Frequently
Someone is watching me.	____Never	____Rarely	____Sometimes	____Frequently
I hear voices in my head.	____Never	____Rarely	____Sometimes	____Frequently
I am out of control.	____Never	____Rarely	____Sometimes	____Frequently

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol dependence	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify)
_____ dizziness	_____ mood shifts	_____
_____ drug dependence	_____ panic attacks	_____
_____ eating disorder	_____ phobias/fears	_____
_____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____
_____
_____
_____
_____

List your four greatest strengths:

1) _____
2) _____
3) _____
4) _____

List your four greatest challenges:

1) _____
2) _____
3) _____
4) _____

List your main social difficulties:

_____
_____

List your main love and sex difficulties:

_____
_____

List your main difficulties at school or work: _____
_____
_____ _____

List your main difficulties at home: _____
_____
_____

List your behaviors that you would like to change:

_____
_____
_____

Additional information you believe would be helpful: _____
_____
_____
_____

PLEASE BRING THIS TO YOUR NEXT APPOINTMENT