Initial Intake for Individual Therapy

DATE CALL RECEIVED: _____/_____/_____ RETURNING CLIENT(S)? YES___ NO ___

DATE INTAKE COMPLETED: _____/_____/_____ DATE SERVICES BEGAN: _____/_____/_____

NAME AGE BIRTHDATE GENDER (F/M/T)

STREET CITY ZIP COUNTY

TELEPHONE NUMBER EMAIL ADDRESS(ES)

WHOM TO CONTACT IN CASE OF EMERGENCY/PHONE TURNED OFF, ETC. PHONE

IS IT SAFE TO LEAVE A MESSAGE? Y N IF NO, INDICATE REASON ON LINE ABOVE.

BEST DAYS & TIMES FOR APPOINTMENT BEST TIMES TO CONTACT BEST WAY TO CONTACT

HOW DO YOU IDENTIFY YOUR ETHNICITY:
HOW DO YOU IDENTIFY YOUR GENDER: [HETEROSEXUAL] [HOMOSEXUAL] [LESBIAN] [TRANSGENDERED] [TRANSSEXUAL] [OTHER] (DESCRIBE)

ARE YOU A STUDENT NOW?	[NO] [FULL TIME] [PART TIME]
WHAT IS THE HIGHEST EDUCATIONAL LEVEL YOU HAVE COMPLETED?	

☐ NONE ☐ SOME COLLEGE ☐ GRADUATE OR PROFESSIONAL DEGREE

☐ ELEMENTARY SCHOOL ☐ COLLEGE DEGREE ☐ GED

☐ HIGH SCHOOL ☐ TECHNICAL SCHOOL ☐ OTHER

WHAT WAS YOUR MAJOR AREA OF STUDY?

Dou you have children?			[YES] [NO]
• In which areas of your life do you seem to have the greatest struggle?			[ME] [THEM]
NAME	RELATIONSHIP	AGE	LIVES AT HOME
1.	[MINE] [STEP] [ORPHAN] [FOSTER]		[YES] [NO]
2.	[MINE] [STEP] [ORPHAN] [FOSTER]		[YES] [NO]
3.	[MINE] [STEP] [ORPHAN] [FOSTER]		[YES] [NO]
4.	[MINE] [STEP] [ORPHAN] [FOSTER]		[YES] [NO]
5.	[MINE] [STEP] [ORPHAN] [FOSTER]		[YES] [NO]

WHAT IS YOUR CURRENT JOB STATUS

☐ FULL-TIME ☐ UNEMPLOYED ☐ TEMPORARILY UNEMPLOYED

☐ PART-TIME ☐ RETIRED ☐ A HOMEMAKER (NOT WORKING OUTSIDE THE HOME)

IF NOT EMPLOYED NOW, HAVE YOU EVER BEEN EMPLOYED IN THE PAST?	[YES] [NO]
• WHY ARE YOU NO LONGER EMPLOYED?	
• IN WHAT LINE OF WORK WERE YOU EMPLOYED?	
• HAVE YOU HAD FORMAL TRAINING FOR YOUR LINE OF WORK?	

RELATIONSHIP STATUS:

PARTNERED	ENGAGED	MARRIED	MARRIED SEPERATED	DIVORCED	COHABITATING	DATING

LENGTH OF CURRENT RELATIONSHIP? _____

LENGTH OF ANY PREVIOUS RELATIONSHIP? _____

DO YOU SHARE YOUR INCOME(S) WITH SOMEONE ELSE? Y N

NUMBER OF PEOPLE SUPPORTED BY YOUR HOUSEHOLD INCOME?

NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD?

IF MARRIED OR IN A COMMITTED RELATIONSHIP, PLEASE CIRCLE THE DESCRIPTION OF THE DEGREE OF YOUR HAPPINESS.

EXTREMELY UNHAPPY	FAIRLY UNHAPPY	A LITTLE UNHAPPY	HAPPY	VERY HAPPY	EXTREMELY HAPPY	PERFECT

In your own words, do you see any major problems in your life that you feel you have no control over at this time?

Would you mind sharing with me some of the reasons you're looking for counseling at this time?

If you could change one thing in your life that would have a the greatest positive affect on you what would it be?

What do you see as your biggest strengths?

What do you see as your biggest opportunities for improvement?

Have you ever been to counseling as a result of this problem prior to today?	[YES] [NO]
• Do you consider the counseling to have been helpful?	[YES] [NO]
Have you ever been in individual counseling before?	[YES] [NO]
• Do you consider the individual counseling to have been successful?	[YES] [NO]
Do you consume alcohol or drugs to the point of intoxication?	[YES] [NO]
Has anyone in your family ever abused alcohol or drugs?	[YES] [NO]
I married or in a committed relationship, has your partner ever struck, physically restrained, used violence against, or injured you within the last 3 years?	[YES] [NO]
If married or in a committed relationships, have either you or your partner threatened marital divorce or separation?	[YES] [NO]
• Which one	[ME] [THEM]

• Did things improve					[YES] [NO]
Do you perceive that you have felt withdrawn emotionally from your life?					[YES] [NO]
• In which areas of your life do you seem to have the greatest struggle?					[ME] [THEM]
Home	Work	Social/friends	Church	Out in public	
How frequently have you had sexual relations in the last month (write number to the right)					
How enjoyable is your sexual relationship? (circle the best response)					
TERRIBLE	MORE UNPLEASANT THAN PLEASANT	NOT PLEASANT NOT UNPLEASANT	MORE PLEASANT THAN UNPLEASANT	GREAT	
How satisfied are you with your sexual relations? (circle the best response)					
WAY TOO OFTEN FOR ME	A BIT TOO OFTEN	ABOUT RIGHT	A BIT TO SELDOM	WAY TO SELDOM FOR ME	
What is your current level of stress?					
EXTREMELY HIGH	VERY HIGH	HIGH	MODERATE	LOW	VERY LOW	EXTREMELY LOW
IS YOUR FATHER STILL ALIVE?						[YES] [NO]
WAS YOUR FATHER PHYSICALLY ABUSIVE TO YOU IN YOUR CHILDHOOD?						[YES] [NO
DID YOUR FATHER ABUSE DRUGS OR ALCOHOL?						[YES] [NO
WHAT IS/WAS YOUR RELATIONSHIP WITH YOUR FATHER LIKE? (CIRCLE ALL THAT APPL)						
CLOSE	SUPPORTIVE	ABSENT	LOVING	DISTANT	STRAINED	HOSTILE
IS YOUR MOTHER STILL ALIVE?						[YES] [NO]
DID YOUR FATHER ABUSE DRUGS OR ALCOHOL?						[YES] [NO
WHAT IS/WAS YOUR RELATIONSHIP WITH YOUR FATHER LIKE? (CIRCLE ALL THAT APPL)						
WHAT IS/WAS YOUR RELATIONSHIP WITH YOUR FATHER LIKE? (CIRCLE ALL THAT APPL)						
CLOSE	SUPPORTIVE	ABSENT	LOVING	DISTANT	STRAINED	HOSTILE
To what degree do you have family or friends that support you? (circle one)						
EXTREMELY SUPPORTIVE	VERY SUPPORTIVE	HIGH	MODERATE	LOW	VERY LOW SUPPORT	EXTREMELY LOW SUPPORT
WHICH OF THE FOLLOWING KNOW ABOUT THE STRUGGLES YOU ARE HAVING THAT HAS BROUGHT YOU IN TO COUNSELING? (CIRCLE ALL THAT APPLY)						

PARTNER	CHILDREN	PARENTS	FRIENDS	PASTOR	WORK ASSOC.	OTHER
TO WHAT DEGREE DO ARE YOU COMMITTED TO SEE YOUR LIFE IMPROVE AND BE MORE SATISFYING? (CIRCLE ONE)						
EXTREMELY HIGH	VERY HIGH	HIGH	MODERATE	LOW	VERY LOW	EXTREMELY LOW

IN YOUR OWN WORDS, WHAT WOULD IT TAKE FOR YOU TO FEEL THIS COUNSELING HAS BEEN SUCCESSFUL?

WHAT CONCERNS DO YOU HAVE ABOUT CONSELING?

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

- ☐ ANGER
- ☐ ANXIETY
- ☐ BI-POLAR
- ☐ IDENTITY ISSUES
- ☐ CHEMICAL DEPENDENCY
- ☐ CHILDHOOD ISSUES
- ☐ CHRONIC ILLNESS
- ☐ DEPRESSION
- ☐ DISABILITY ISSUES
- ☐ DISORDERED EATING
- ☐ DIVORCE
- ☐ ABUSE/VIOLENCE
- ☐ FINANCIAL STRESS
- ☐ GRIEF AND LOSS
- ☐ BI POLAR/MOOD SWINGS
- ☐ LEGAL CHALLENGES
- ☐ PARENTING ROLE
- ☐ PARTNER RELATIONSHIP
- ☐ SELF-ESTEEM
- ☐ SEXUAL ASSAULT
- ☐ SUICIDALITY

HAVE YOU EVER BEEN DIAGNOSED WITH ANY MENTAL ILLNESS OR PSYCHIATRIC DISORDER?	[YES] [NO]
• DESCRIBE WHAT YOU WERE DIAGNOSED WITH	
HAVE YOU EVER BEEN HOSBITALIZED FOR ANY MENTAL ILLNESS OR PSYCHIATRIC DISORDER?	[YES] [NO]
HAVE YOU EVER MADE ANY ATTEMPT TO TAKE YOUR LIFE?	[YES] [NO]
• ARE YOU FEELING LIKE YOU WANT TO TAKE YOUR LIFE NOW?	[YES] [NO]
• IF YES, DESCRIBE THE PLAN AND THE MEANS BY WHICH YOU WOULD PROCEED	
ARE YOU TAKING ANY MEDICATIONS NOW?	[YES] [NO]
PLEASE LIST ANY MEDICATIONS YOU ARE ON:	

Family History/Genogram*

*****T*o be completed with your counselor during the session*