INTAKE /ASSESSMENT FORM

Welcome! These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

CLIENT INFORMATION

Name:____

Date of Birth:_______________________________ Age: ____________ ❐ Male ❐ Female

Address:____

Occupation: _______________________________ Employer: ________________________

School (if student):____

Phone (h): ______________________________ Messages ok at home? ❐ Yes ❐ No

Phone (cell): ____________________________ Messages ok on cell? ❐ Yes ❐ No
(Note: I cannot guarantee the confidentiality of cell conversations.)

Phone (w):______________________________ Messages ok at work? ❐ Yes ❐ No

Email: _________________________________ Emails ok? ❐ Yes ❐ No
(Note: I cannot guarantee the confidentiality of email.)

Website: ____
May I have your permission to look at your website? ❐ Yes ❐ No

How did you find out about my services? _____________________________________
If referred by a person, may I have your permission to thank him/her? ❐ Yes ❐ No

Religious Affiliation: ____

Ethnic/Cultural Heritage: ____
____

MARITAL STATUS

❐ Single ❐ Married (legally) ❐ Divorced Total # of marriages:_______________

❐ Cohabitating ❐ Divorce in process ❐ Separated ❐ Widowed Other:_______________

Assessment of current relationship (if applicable): ❐ Good ❐ Fair ❐Poor

Comments:____
____

FAMILY INFORMATION

Relationship	Name	Age	Sex	Type(bio, step, etc.)	Living with you?
Mother					❒ Yes ❒ No
Father					❒ Yes ❒ No
Spouse/SO					❒ Yes ❒ No
Children/					❒ Yes ❒ No
Siblings					❒ Yes ❒ No
					❒ Yes ❒ No
					❒ Yes ❒ No

(Continue on back if needed)

EDUCATION

Fill in all that apply: Years of education: ______________ Currently enrolled: ❒ Yes ❒ No

__________High School grad/GED __________College

__________Vocational: __________Graduate School

Other training:____

Special circumstances:____

MILITARY

Military experience? ❒ Yes ❒ No Combat experience? ❒ Yes ❒ No

Where: ____________________________ Branch: ____________________________

Type of discharge: ____________________ Length of service: ____________________

Rank at discharge: ____________________

PERSONAL STRENGTHS

What do you do well and what activities do you enjoy? ______________________________

____

____

What personal qualities would others say you have? ______________________________

____

____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) ______________________________

____

____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

Approximate Dates of Counseling: ______________________________________

For what reason? ____

What did you find **most helpful** in therapy? ______________________________

____

What did you find **least helpful** in therapy? ______________________________

____

Have you used psychiatric services? Yes No Was it helpful? Yes No
Please describe. ____
____

Have you taken medication for a mental health concern? Yes No

Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe. __________
____
____

LEGAL ISSUES
Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.____
____

CURRENT REASON FOR SEEKING COUNSELING
Briefly describe the problem for which you/your adolescent desire to have counseling? __________
____
____

What would you like to see happen as a result of counseling? ______________________
____
____

What is most concerning right now? ____
____
____

CURRENT FAMILY AND SIGNIFICANT RELATIONSHIPS
Strengths/supports (relationships, support groups, etc.)
____
____

Stressors/problems
____
____

Recent changes
____
____

Changes desired
____
____

FAMILY CONCERNS

Please check any family concerns that you are having.

❒ Fighting	❒ Education problems	❒ Disagreeing about Friends	❒ Other
❒ Feeling Distant	❒ Money	❒ Alcohol Use	❒ Other
❒ Loss of fun	❒ Disagreeing about Relatives	❒ Drug Use	
❒ Lack of honesty		❒ Infidelity	
❒ Physical fights			

Comments: ____

____

SUBSTANCE USE

Please check substances you use on a weekly/monthly (circle) basis:

Alcohol	_______ x per week / month	Heroine	_______ x per week / month
Marijuana	_______ x per week / month	Meth	_______ x per week / month
Cocaine	_______ x per week / month	Ecstasy	_______ x per week / month

Check all that apply:

______ I believe that my substance use may be a problem.

______ I believe that my partner's substance use may be a problem.

INDIVIDUAL CONCERNS

Please check any personal concerns that you are having:

❒ Sadness ____________	❒ Hurting self ____________
❒ Crying ____________	❒ Hurting others ____________
❒ Irritability ____________	❒ Anger/Rage ____________
❒ Loss of pleasure ____________	❒ Abuse (childhood) ____________
❒ Sleep problems ____________	❒ Abuse (adult) ____________
❒ Eating problems ____________	❒ Distractible ____________
❒ Hopelessness ____________	❒ Hearing things ____________
❒ Guilt ____________	❒ Seeing things ____________
❒ Mood swings ____________	❒ Loneliness ____________
❒ Fear ____________	❒ Grief/loss ____________
❒ Nightmares ____________	❒ Work issues ____________
❒ Flashbacks ____________	❒ Spirituality issues ____________
❒ Obsessions ____________	❒ Alcohol Use ____________
❒ Anxiety ____________	❒ Another's Alcohol Use ____________
❒ Panic ____________	❒ Drug Use ____________
❒ Suicidal thoughts ____________	❒ Another's Drug Use ____________
❒ Suicidal acts ____________	❒ Other____________

Comments:____

Is there anything else you would like to share: ______________________________________

____

I understand that by signing below, I am stating the above information is true.

______________________________	____________________
Client Signature	Date
______________________________	____________________
Parent (or guardian) Signature	Date