INTAKE INFORMATION

I'd like to get some background information from you ahead of time so that you don't have to spend your entire first session explaining it all to me. While I may need to ask you some additional questions to clarify, your completion of this form should help me understand your situation more quickly. I appreciate you taking the time to provide this information. Thank you.

Name: ____ ***Date:*** ______________

Please check all of the behaviors and symptoms that are problems for you:

Anxiety Issues
- ☐ *Frequent worry*
- ☐ *Panic attacks*
- ☐ *Social discomfort*
- ☐ *Fear away from home*
- ☐ *Phobias*____________
- ☐ *Obsessive thoughts*
- ☐ *Compulsive behavior*______
- ☐ *Flashbacks*
- ☐ *Nightmares*
- ☐ *Suspicion/paranoia*

Mood Issues
- ☐ *Crying spells*
- ☐ *Sadness/depression*
- ☐ *Fatigue*
- ☐ *Lack of motivation*
- ☐ *Hopelessness*
- ☐ *Guilt*
- ☐ *Inability to enjoy things*
- ☐ *Low self worth*
- ☐ *Shame*
- ☐ *Wide mood swings*
- ☐ *Withdrawal from people*
- ☐ *Self-harm behaviors*
- ☐ *Thoughts of death/suicide*

Attention Issues
- ☐ *Distractibility*
- ☐ *Hyperactivity*
- ☐ *Impulsivity*
- ☐ *Easily confused*
- ☐ *Poor memory*
- ☐ *Racing thoughts*

Anger Issues
- ☐ *Physical aggression*
- ☐ *Irritability/anger*
- ☐ *Homicidal thoughts*
- ☐ *Peer conflict*
- ☐ *Property destruction*

General Issues
- ☐ *Alcohol/drug use*
- ☐ *Computer addiction*
- ☐ *Eating problems*
- ☐ *Gambling problems*
- ☐ *Problems with pornography*
- ☐ *Parenting problems*
- ☐ *Relationship problems*
- ☐ *Sexual problems*
- ☐ *Social isolation*
- ☐ *Sleep problems*
- ☐ *Work/school problems*

Child/Adolescent Only
- ☐ *Curfew violation*
- ☐ *Defiance*
- ☐ *Fire setting*
- ☐ *Lying*
- ☐ *Running away*
- ☐ *Sibling conflict*
- ☐ *Stealing*
- ☐ *Toileting problems*

Other Issues
- ☐ *Hearing voices*
- ☐ *Visual hallucinations*
- ☐ __________________
- ☐ __________________

Have you ever attempted to commit suicide? ☐ *No* ☐ *Yes, when?* ________________________

Have you ever attempted to assault or kill someone? ☐ *No* ☐ *Yes, when?* ___________________

Have you ever been physically hurt/threatened by someone? ☐ *No* ☐ *Yes, when?* ____________

Please check if you have experienced any of the following types of trauma or loss:

- ☐ *Emotional abuse*
- ☐ *Sexual abuse*
- ☐ *Physical abuse*
- ☐ *Neglect*
- ☐ *Parent substance abuse*
- ☐ *Parent illness (during your childhood)*
- ☐ *Teen pregnancy*
- ☐ *Placed a child for adoption*
- ☐ *Lived in a foster home*
- ☐ *Multiple family moves*
- ☐ *Violence in the home*
- ☐ *Homelessness*
- ☐ *Crime victim*

Were there any problems with your birth (i.e., fetal distress, emergency c-section, etc)?
☐ *No* ☐ *Yes, what?* ____

Did you have any extreme sensitivity to noise, texture, or taste as a young child?
☐ *No* ☐ *Yes, what?* ____

Name: ____

FAMILY INFORMATION

☐ *Parents legally married or living together*
☐ *Parents temporarily separated*
☐ *Parents divorced or permanently separated*
☐ *Mother remarried: Number of times _________*
☐ *Father remarried: Number of times _________*
☐ *Parent deceased: Which one? _____________*

Parents' ages: Mother ______ Father ______ Stepmother ______ Stepfather ______

Your place in birth order (oldest, youngest, etc): ________________

Brothers and their ages:____

Sisters and their ages: ____

Marital Status: ☐ *Single* ☐ *Married (____ years)* ☐ *Living as married (____ years)*
☐ *Separated (____ years)* ☐ *Divorced (____ years)* ☐ *Widowed(____ yrs)*

Partner name and age (if applicable): ____

Children and their ages: ____

Have any of your family members experienced any of the following:

Issue	*Who?*
Attention/Hyperactivity Problems	___________________________
Anxiety	___________________________
Panic Attacks	___________________________
Obsessive/Compulsive Behavior	___________________________
Depression	___________________________
Manic Depression (Bipolar)	___________________________
Schizophrenia	___________________________
Anger Management Problems	___________________________
Abusive Behavior	___________________________
Suicide Attempts	___________________________
Eating Disorder	___________________________
Sexual Abuse Survivor	___________________________
Alcohol Abuse	___________________________
Drug Abuse	___________________________

PREVIOUS MENTAL HEALTH TREATMENT

Have you had previous counseling? ☐ *No* ☐ *Yes, when? ________________________________*
With whom? _____________________________
For what issue? ___________________________

Do you take any medication for mental health reasons? ☐ *No* ☐ *Yes, which ones, what dosage, and for how long? ____*

Have you ever been hospitalized for a psychiatric reason? ☐ *No* ☐ *Yes, when? ________________*

Have you ever had substance abuse treatment? ☐ *No* ☐ *Yes, when?___________________________*

Do you participate in any support groups? ☐ *No* ☐ *Yes, which? ___________________________*

Name: ____

SUBSTANCE USE

How often do you drink caffeine?____________ How many drinks do you have at a time? ________

How often do you smoke cigarettes? ____________ How many do you smoke per day? __________

How often do you drink alcohol? ____________ How many drinks do you have at a time? ________

Do you use any other recreational substances (marijuana, ecstasy, cocaine, etc)?
☐ *No* ☐ *Yes, which ones, how often? ______________________________ ______________*

Has anyone ever expressed concern about your substance use? ☐ *No* ☐ *Yes*

MEDICAL INFORMATION

When was your last physical? __________________

Have you ever experienced any of the following medical conditions?

☐ *Head injury* ☐ *Frequent stomach upset* ☐ *Miscarriage*
☐ *Fainting spells* ☐ *Diabetes* ☐ *Abortion*
☐ *Seizures* ☐ *Sexually transmitted disease* ☐ *Asthma*
☐ *Chronic pain* ☐ *Migraines* ☐ *Hysterectomy*
☐ *Other: ________________*

Please list any CURRENT health concerns: ____

MISCELLANEOUS INFORMATION

Employment

Employer: ________________________________ Position: _______________________

Length of time in this position: ________ Stress level of this position: ☐ *Low* ☐ *Medium* ☐ *High*

Education

Highest Level of Education Completed: ______ Are you currently attending school? ☐ *No* ☐ *Yes*

Military Service

Have you been/are you now in the military? ☐ *No* ☐ *Yes*

If yes, were you in combat? ☐ *No* ☐ *Yes, when/where? ______________________________*

Legal

Have you ever been convicted of a felony? ☐ *No* ☐ *Yes, what/when? _______________________*

Are you currently involved in any divorce or child custody proceedings? ☐ *No* ☐ *Yes, please explain ____*

Social

Are you involved in any type of spiritual practice? ☐ *No* ☐ *Yes, which? _______________________*

Do you have a local support network (friends, family, church, etc)? ☐ *No* ☐ *Yes*

Race (optional) ________________ Sexual Orientation (optional) ___________________

SCHOOL FUNCTIONING (CHILDREN ONLY)

Child's year (ex., 5th grade): ______________Child's academic performance (As, Bs, etc): __________

Has there been a drop in grades recently? ☐ *No* ☐ *Yes*

Child's behavior and/or attendance problems: ____________________________________

Has there been an increase in behavior problems at school recently? ☐ *No* ☐ *Yes*

Is there any special education plan in place? ☐ *No* ☐ *Yes, what? ___________________________*

******If there is any other information that you would like to provide, please feel free to attach it.******