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INTAKE INFORMATION

I'd like to get some background information from you before we begin working together. 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: _____ ***Age:*** _____ ***Date of Birth:*** ___/___/____ ***Date:***___/___/____

*Current Address:*_____*City*_____*State*_____*Zip*_____

*Permanent Address:*_____*City*_____*State*_____*Zip*_____

Home Phone: _____ *Cell Phone:* _____*Work Phone:* _____

May I contact you at home? ☐ *No* ☐ *Yes ~ On your cell phone?* ☐ *No* ☐ *Yes ~ May I call you at work?* ☐ *No* ☐ *Yes*

May I leave a message on your cell phone? ☐ *No* ☐ *Yes* *May I leave a message for you at your home?* ☐ *No* ☐ *Yes*

May I contact you using my cell phone? ☐ *No* ☐ *Yes* *Email Address:* _____

May I contact you by email? ☐ *No* ☐ *Yes* *How often do you check your email?* _____

Emergency Contact:
In case of an emergency please notify: _____

Emergency Phone Number(s): _____ *Relationship:* _____

Do I have permission to contact the individual listed in case of emergency? ☐ *No* ☐ *Yes*
If contacted, information will be carefully disclosed.

Gender: ☐ *Male* ☐ *Female* ☐ *Transgender* ☐ *Non-binary* ☐ *Other*_____

What race or culture do you consider yourself? (Check all that apply.)

☐ *Black/African American*

☐ *African*
*(Specify:*_____*)*

☐ *Middle Eastern/North African*
*(Specify:*_____*)*

☐ *Asian*
*(Specify:*_____*)*

☐ *Asian American*

☐ *American Indian* *Please identify name of the enrolled or principal tribe:*

_____

☐ *Hawaiian*

☐ *Pacific Islander*
*(Specify:*_____*)*

☐ *SE Asian*
*(Specify:*_____*)*

☐ *South Indian*

☐ *Caucasian/White/Euro-American*

☐ *Puerto Rican*

☐ *Cuban*

☐ *Spanish/Latino (Argentinean, Colombian, Dominican, Nicaraguan, Spanish, Salvadoran, etc.)*

☐ *Mexican, Mexican American, Chicano*

☐ *Other:*_____

Sexual Orientation:

☐ *Heterosexual* ☐ *Gay/Lesbian* ☐ *Bisexual* ☐ *Fluid*

☐ *Queer* ☐ *Questioning* ☐ *Other*_____

Relationship Status:

☐ *Single* ☐ *Engaged* ☐ *Married* ☐ *Partnered* ☐ *Separated* ☐ *Divorced* ☐ *Remarried* ☐ *Widow/Widower*
Is your spouse/partner supportive of you seeking counseling? ☐ *No* ☐ *Yes*

Number of children: _____ Children's Ages: _____

Academic Status (if you are a student):

Academic Institution: _____

Year in College: _____Number of credits: _____ Current GPA: _____

Referred by:

☐ *Self* ☐ *Parent/Family* ☐ *Instructor/Professor* ☐ *Friend/Fellow Student* ☐ *Counselor/Psychologist*

☐ *Academic Advisor* ☐ *Other:_____*

PREVIOUS MENTAL HEALTH TREATMENT

Have you had previous counseling? ☐ *No* ☐ *Yes When?_____*
With whom? _____ For what issue? _____
Most helpful aspect? _____ Least helpful? _____

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 and for what reasons?_____*
_____
_____

Have you ever had substance abuse treatment? ☐ *No* ☐ *Yes When?_____*

Do you participate in any support groups? ☐ *No* ☐ *Yes Which? _____*

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

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

MEDICAL INFORMATION

When was your last physical? _____
Have you <u>ever</u> experienced any of the following medical conditions?

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

Please list any CURRENT health concerns: _____

Please check all of the <u>BEHAVIORS AND SYMPTOMS</u> that are concerns for you:

<u>Anxiety Issues</u>	☐ *Withdrawal from people*	☐ *Parenting problems*
☐ *Frequent worry*	☐ *Self-harm behaviors*	☐ *Relationship problems*
☐ *Panic attacks*	☐ *Thoughts of death/suicide*	☐ *Sexual problems*
☐ *Social discomfort*	***<u>Attention Issues</u>***	☐ *Social isolation*
☐ *Fear away from home*	☐ *Distractibility*	☐ *Sleep problems*
☐ *Phobias_____*	☐ *Hyperactivity*	☐ *Work/school problems*
☐ *Obsessive thoughts*	☐ *Impulsivity*	***<u>Child/Adolescent Only</u>***
☐ *Compulsive behavior*	☐ *Easily confused*	☐ *Curfew violation*
☐ *Flashbacks*	☐ *Poor memory*	☐ *Defiance*
☐ *Nightmares*	☐ *Racing thoughts*	☐ *Fire setting*
☐ *Suspicion/paranoia*	***<u>Anger Issues</u>***	☐ *Lying*
<u>Mood Issues</u>	☐ *Physical aggression*	☐ *Running away*
☐ *Crying spells*	☐ *Irritability/anger*	☐ *Sibling conflict*
☐ *Sadness/depression*	☐ *Homicidal thoughts*	☐ *Stealing*
☐ *Fatigue*	☐ *Peer conflict*	☐ *Toileting problems*
☐ *Lack of motivation*	☐ *Property destruction*	***<u>Other Issues</u>***
☐ *Hopelessness*	***<u>General Issues</u>***	☐ *Hearing voices*
☐ *Guilt*	☐ *Alcohol/drug use*	☐ *Visual hallucinations*
☐ *Inability to enjoy things*	☐ *Computer addiction*	☐ *Acculturation/Cultural Adjustment*
☐ *Low self-worth*	☐ *Eating problems*	☐ *Spiritual/Religious Matters*
☐ *Shame*	☐ *Gambling problems*	☐ *Death of a Loved One*
☐ *Mood swings*	☐ *Problems with pornography*	☐ *Other_____*

Please state the reason(s) and concern(s) for which you are seeking counseling and any other helpful information:

_____

_____

_____

_____

*How long have these concern(s) been bothering you?*_____

_____

RISK OF HARM TO SELF OR OTHERS

Have you ever in your lifetime had thoughts of harming yourself? ☐ *No* ☐ *Yes*

Have you purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling, etc.)?

☐ *No* ☐ *Yes* ☐ *In the past, but stopped* ☐ *In the past and currently going on* ☐ *Recently started*

In the last week, have you had suicidal thoughts (i.e., thoughts of killing yourself)? ☐ *No* ☐ *Yes*

If yes, what is the frequency? ☐ *N/A* ☐ *Rarely* ☐ *Sometimes* ☐ *Frequently* ☐ *Always*

What is the duration? ☐ *N/A* ☐ *Seconds* ☐ *Minutes* ☐ *Hours* ☐ *Constant*

What is the intensity? ☐ *N/A* ☐ *Brief and fleeting* ☐ *Focused deliberation* ☐ *Intense rumination*

Have you seriously considered attempting suicide in the past? ☐ *No* ☐ *Yes*

Have you ever attempted to commit suicide? ☐ *No* ☐ *Yes When?* _____

Did you receive help? ☐ *No* ☐ *Yes Where?*_____

Have you seriously considered harming another person? ☐ *No* ☐ *Yes Whom?*_____

*When?*_____

Have you intentionally physically harmed someone? ☐ *No* ☐ *Yes When?*_____

Have you ever been physically hurt/threatened by someone? ☐ *No* ☐ *Yes When?* _____

*What have you found helpful to cope during difficult times?*_____

_____

_____

FAMILY INFORMATION

☐ *Parents married/partnered & living together* ☐ *Mother remarried: Number of times* _____

☐ *Parents temporarily separated* ☐ *Father remarried: Number of times* _____

☐ *Parents divorced or permanently separated* ☐ *Parent deceased: Which one?* _____

Parents' /Guardians' ages: Mother(s) _____/_____ *Father(s)* _____/_____ *Stepmother* _____ *Stepfather* _____

*Brothers and their ages:*_____

Sisters 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 _____

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?* _____

Do you regularly use alcohol? ☐ *No* ☐ *Yes*

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

☐ *Never* ☐ *Rarely* ☐ *Monthly* ☐ *Weekly* ☐ *Daily or Almost Daily*

Do you consider your alcohol consumption a problem? ☐ *No* ☐ *Yes*

Have you used any drug in the past 30 days that was not prescribed by a doctor (for example, marijuana, meth, cocaine, diet pills, ecstasy, Xanax, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other?) ☐ *No* ☐ *Yes*

How often do you engage in recreational drug use? ☐ *Never* ☐ *Rarely* ☐ *Monthly* ☐ *Weekly* ☐ *Daily/Almost Daily*

Has anyone ever expressed concern about your drinking or drug use? ☐ *No* ☐ *Yes*

Have you ever tried to stop your drinking or drug use, but could not? ☐ *No* ☐ *Yes*

MISCELLANEOUS INFORMATION

Employment
Employer: _____*Position:* _____
Length of time in this position: _____ *Stress level of this position:* ☐ *Low* ☐ *Medium* ☐ *High*

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:*_____

_____

Community
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 Which?* _____

Please answer the following 5 questions based on how you've felt* ***in general over the past week****

1) I feel sad, blue, or down….

☐ *I do not feel sad, down, or blue.*
☐ *rarely.*
☐ *sometimes.*
☐ *often (more times than not).*

2) My appetite…

☐ *My appetite is normal and hasn't changed.*
☐ *is somewhat lower* ***OR*** *higher than normal.*
☐ *is significantly lower* ***OR*** *higher than normal.*
☐ *has changed so much that I do not want to eat at all* ***OR*** *I want to eat all the time.*

3) My energy level…

☐ *My energy level is normal.*
☐ *is noticeably lower than normal.*
☐ *is much lower than normal.*
☐ *is so low that I can hardly conduct my daily activities (work, school, hygiene).*

4) I have lost interest and pleasure in things that I usually enjoy…

☐ *I have interest in things I usually enjoy & get as much pleasure from them as I always have.*
☐ *I have lost* ***some*** *of my interest in things, but still enjoy activities & get pleasure from some activities.*
☐ *I have lost interest and pleasure in* ***most t****hings.*
☐ *I have lost interest and pleasure in* ***all*** *things.*

5) I feel guilty and down on myself…

☐ *I do not feel guilty or down on myself.*
☐ *sometimes.*
☐ *much of the time.*
☐ *all of the time.*

<u>*Relationships*</u> : *Rate on the scale of 1 to 5, with 1 being low and 5 being high:*

Rate the general relationship with your father(s): _____ _____
Rate the general relationship with your mother(s): _____ _____
Rate the general relationship with your siblings: _____
If you are in an intimate relationship, rate it in general terms: _____
Rate your general relationships with your friends: _____
If you are living with roommates, rate your relationship with your roommate(s): _____
If you have a job, rate your relationship with your work colleagues: _____
If you have children, rate your relationship with them (could vary with each child): _____

******If there is any other information that you would like to provide, please feel free to include it here:***

_____

_____

_____

Thank you for taking the time to complete this confidential information form