COUNSELING INTAKE FORM

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Basic Information

Name: ______________________ Age: __________ Date: __________

Full Address: ____

Date of Birth: ______________________ SSN ______________________________

Home Phone: ______________________ May I leave a Message? ☐ Y ☐ N

Cell Phone: ______________________ May I text? ☐ Y ☐ N

Email Address: ______________________ May I send an email? ☐ Y ☐ N

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ In a Relationship

Children: Name: ______________________ Age: __________

Name: ______________________ Age: __________

Name: ______________________ Age: __________

Name: ______________________ Age: __________

Emergency Contact:

Name: ____ Relationship: ___________________

Phone Number: _________________________ Address: ____

Presenting Challenges and Problem History

Describe why you are seeking therapeutic services:

____

____

____

What challenges would you like to overcome?

____

____

____

Family History

1. Were your parents ☐ Married ☐ Living Together ☐ Unmarried but in a relationship with each other ☐ Divorced ☐ Separated ☐ Remarried ☐ Other:
   ____
   ____
2. Are you adopted: ☐ Yes ☐ No
3. Did your family have adequate food, shelter, and other basic needs met? ☐ Yes ☐ No If no, explain: ____
4. Did you feel loved growing up? ☐ Yes ☐ No If no, explain:

   ____
   ____
5. How were you punished or disciplined? ____
6. Describe the values you learned growing up in your family?

   ____
   ____
7. Is there a history of substance abuse, addictions, or mental illness in your family?

   ____
   ____
8. Did you experience any incest, molestation, or inappropriate touch? ☐ Yes ☐ No If yes, explain:

   ____
   ____
9. Describe what it was like for you growing up in your family:

   ____
   ____

Spiritual History

Religious Upbringing: ______________________ Preset Affiliation: ______________________

Is this an important part of your life? ☐ Yes ☐ No

Why or why not?

____

____

Social History and Relationships

1. Describe your current support system: ____
2. Is it easy for you to make and keep friends? ☐ Yes ☐ No If no, explain

____

____

3. Are you in a relationship with someone at present? ☐ Yes ☐ No If yes, describe relationship and your level of satisfaction with the relationship:

____

____

4. Is it easy for you to develop and maintain romantic relationships? ☐ Yes ☐ No If no, explain:

____

____

5. Describe leisure/recreational activities you engage in and/or enjoy:

____

____

Sexual History

1. Are you sexually active? ☐ Yes ☐ No
2. Age at which you became sexually active: ____
3. Number of sexual partners in the last 12 months: _________________________________
4. Number of sexual partners in your lifetime: ____
5. Is sex mechanical or emotional? ____
6. Are you currently in a sexual relationship? ☐ Yes ☐ No
7. Are you satisfied with this relationship? ☐ Yes ☐ No
8. Would you describe yourself as: ☐ Heterosexual ☐ Heterosexual with some same-sex attraction ☐ Bisexual ☐ Gay/Lesbian ☐ Gay/Lesbian with some opposite sex attraction ☐ Asexual ☐ Transgender ☐ Questioning
9. Have you ever been bullied, physically or emotionally harmed because of your sexuality? ☐ Yes ☐ No If yes, describe: ____
10. Have you ever been forced or coerced to have sex? ☐ Yes ☐ No ☐ Not sure

____

____

11. Do you need alcohol or other drugs to feel comfortable having sex? ☐ Yes ☐ No

____

12. Have you paid or exchanged sex for money, alcohol or other drugs? ☐ Yes ☐ No
13. Have you ever been diagnosed with a sexually transmitted disease/infection (STD/SDI)? ☐ Yes ☐ No If yes, what: ____
14. Do your sexual thoughts, feelings and/or activities cause any problems in your relationship with your spouse/partner/significant other? ☐ Yes ☐ No
15. At what age were you first exposed to pornography? ____________________________
16. Does pornography play an important part in your sexual thoughts, feelings or behaviors? ☐ Yes ☐ No
17. How many times each week do you seek out pornographic images or videos? ____
18. Have you used/engaged in any of the following: ☐ Chat rooms/other internet sites ☐ Group sex or sex with multiple partners ☐ Strip clubs/stripping ☐ Prostitution
19. Have you ever been arrested or nearly so because of sexual activities? ☐ Yes ☐ No
20. Do you sometimes think you masturbate excessively? ☐ Yes ☐ No
21. Do you have any questions or concerns about your sexuality, sexual relationship(s) or sexual health you would like to discuss with your counselor? ☐ Yes ☐ No

____

____

Emotional/Psychological/Behavioral Health Issues or Needs

1. Have you ever been diagnosed with a psychiatric illness *(including but not limited to depression, anxiety, eating disorder, bipolar disorder, etc.)*? ☐ Yes ☐ No If yes, what and by whom?

____

____

2. Health Checklist: *Check all that apply to each family member and yourself*

	You	Spouse	Child	Parent	Briefly Explain
Anxiety	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Drinking	☐	☐	☐	☐	
Substance Abuse	☐	☐	☐	☐	
Anger/Rage	☐	☐	☐	☐	
Workaholism	☐	☐	☐	☐	
Food Addiction	☐	☐	☐	☐	

Problems with spending/gambling	☐	☐	☐	☐	
Sex/pornography addiction	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	

3. Do you currently have a psychiatrist? ☐ Yes ☐ No If yes, name and contact number: _________
____

4. Do you currently have a therapist? ☐ Yes ☐ No If yes, name and contact number: __________
____

5. Have you ever received treatment and/or been hospitalized for the above diagnosed illness? ☐ Yes ☐ No If yes, date, level of care (OP, IOP, Residential/inpatient), facility, and length of stay:

____
Date Level of Care Facility Name Length of Stay

____
Date Level of Care Facility Name Length of Stay

Assessment of Risk

A. Current risk factors: (check all that apply)

1. Suicidal: ☐ Yes ☐ No ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
   If yes, explain: ____
2. Homicidal: ☐ Yes ☐ No ☐ Ideation ☐ Plan ☐ Intent w/o means ☐ Intent with means
   If yes, explain: ____
   ____
3. Self-Injury: ☐ Yes ☐ No If yes, explain: ____
   ____
4. Impulse control: ☐ Sufficient ☐ Moderate ☐ Minimal ☐ Inconsistent ☐ Explosive
5. Medical risks: ☐ Yes ☐ No If yes, explain: _______

B. Risk History:

1. Suicide: ☐ Yes ☐ No If yes, explain: ____
2. Homicide: ☐ Yes ☐ No If yes, explain: ____
3. Self Injury: ☐ Yes ☐ No If yes, explain: ____
   ____

C. Trauma:

What are the three most traumatic things you have experienced?

1.

____

____

2.

____

____

3.

____

____

Strengths and Barriers to Achieving Treatment Goals

1. Describe any barriers you believe might interfere with your ability to accomplish your goals:

____

____

2. What are your top three strengths?

____

____

3. How would you like your life to be different when you accomplish your therapeutic goals?

____

____

Thank you for taking the time to complete this information.

This is strictly confidential!

Current Medications:

Name	Dose/Frequency	Prescribed By	For what condition