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**INTAKE FORM**

TODAY'S DATE: \_\_/\_\_/\_\_ DOB: \_\_/\_\_/\_\_  
LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

**PRESENT MAILING ADDRESS:**

\_\_\_\_\_  
STREET CITY STATE ZIP CODE  
Y/N Y/N

HOME PHONE OK TO LEAVE MSG? CELL PHONE OK TO LEAVE MSG?

EMAIL ADDRESS: \_\_\_\_\_ OK TO EMAIL YOU? Y/N

DO YOU HAVE HEALTH INSURANCE? Yes  No  IF YES, NAME OF COMPANY: \_\_\_\_\_

**YOUR RESIDENCE:**

WHO LIVES IN YOUR HOME: \_\_\_\_\_  
\_\_\_\_\_

ARE YOU EMPLOYED?: Yes  No  TYPE OF WORK: \_\_\_\_\_ HOURS PER WEEK: \_\_\_\_\_

**WHO REFERRED YOU TO COUNSELING (CHECK ALL THAT APPLY)?**

SELF  EMPLOYER  FRIEND  PHYSICIAN  COURT  FAMILY  
OTHER: \_\_\_\_\_

**THERAPY IS BENEFITTED BY COUNSELORS' UNDERSTANDING OF CLIENTS' CULTURAL CONTEXTS.**

RACIAL/CULTURAL/ETHNIC IDENTITY: \_\_\_\_\_

SEXUAL IDENTITY: \_\_\_\_\_

PRIMARY SPOKEN LANGUAGE: \_\_\_\_\_ LANGUAGE SPOKEN AT HOME: \_\_\_\_\_

**EDUCATIONAL INFORMATION:**

SOME HIGH SCHOOL  COMPLETED HIGH SCHOOL  SOME COLLEGE  
 COMPLETED BA/BS  SOME GRAD SCHOOL  COMPLETED GRAD SCHOOL

OTHER: \_\_\_\_\_

**ROMANTIC PARTNER STATUS:**

- SINGLE/NON-PARTNERED. HOW LONG? \_\_\_\_\_
- DATING. HOW LONG? \_\_\_\_\_
- SIGNIFICANT RELATIONSHIP. HOW LONG? \_\_\_\_\_
- MARRIED/PARTNERED. HOW LONG? \_\_\_\_\_
- DIVORCED/DIVORCE HISTORY. HOW LONG? \_\_\_\_\_
- SEPARATED. HOW LONG? \_\_\_\_\_

ADDITIONAL INFORMATION REGARDING SIGNIFICANT RELATIONSHIPS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY:**

AGE OF PARENTS: MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_ WHO PRIMARILY RAISED YOU? \_\_\_\_\_  
 IF YOUR PARENT(S) IS/ARE DECEASED, WHEN? MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_  
 PARENTS' RELATIONSHIP STATUS:  MARRIED  DIVORCED  SEPARATED  OTHER \_\_\_\_\_  
 WHEN? \_\_\_\_\_  
 DO YOU HAVE CHILDREN? YES  NO   
 IF YES, PLEASE LIST AGES: \_\_\_\_\_  
 HAS ANYONE IN YOUR FAMILY BEEN HOSPITALIZED FOR PSYCHOLOGICAL REASONS? YES  NO   
 IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 HAS ANYONE IN YOUR FAMILY HAD AN ALCOHOL OR SUBSTANCE ABUSE PROBLEM? YES  NO   
 IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 HAS ANYONE IN YOUR FAMILY HAD A MENTAL HEALTH PROBLEM (E.G., DEPRESSION, BIPOLAR DISORDER, SCHIZOPHRENIA, ETC.)? YES  NO  IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL AND MENTAL HEALTH HISTORY:**

DO YOU HAVE ANY MEDICAL CONDITIONS? Yes  No   
 PLEASE SPECIFY: \_\_\_\_\_  
 ARE YOU CURRENTLY TAKING MEDICATIONS? Yes  No   
 NAMES OF MEDICATIONS: \_\_\_\_\_  
 WHO PRESCRIBED THEM FOR YOU? \_\_\_\_\_  
 DO YOU HAVE A DOCUMENTED DISABILITY? Yes  No   
 IF YES, PLEASE DESCRIBE: \_\_\_\_\_  
 \_\_\_\_\_  
 HAVE YOU PREVIOUSLY HAD COUNSELING/PSYCHOTHERAPY? Yes  No   
 IF YES, PLEASE SPECIFY WHEN, WHY, AND WAS IT HELPFUL? \_\_\_\_\_  
 \_\_\_\_\_  
 HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL HEALTH REASONS? Yes  No   
 IF YES, PLEASE DESCRIBE: \_\_\_\_\_  
 \_\_\_\_\_  
 HAVE YOU SERIOUSLY CONSIDERED ATTEMPTING SUICIDE IN THE PAST? Yes  No   
 IF YES, WHEN? \_\_\_\_\_  
 HAVE YOU EVER MADE A SUICIDE ATTEMPT IN THE PAST? Yes  No   
 IF YES, WHEN? \_\_\_\_\_

**CHECKLIST OF PERSONAL CONCERNS**

<b>I AM CONCERNED ABOUT:</b>	<b>NO CONCERN</b>	<b>MODERATE CONCERN</b>	<b>SERIOUS CONCERN</b>
MAKING OR KEEPING FRIENDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MAKING OR KEEPING A ROMANTIC PARTNER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONFLICT WITH A ROMANTIC PARTNER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY WITH CHILDREN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONFLICT WITH OTHER FAMILY MEMBER(S)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONFLICT WITH FRIENDS/COWORKERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE BEING OPEN WITH OTHERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE ADJUSTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEXUALITY AND/OR SEXUAL IDENTITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEELING LONELY AND/OR NOT FITTING IN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RELIGIOUS OR SPIRITUAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE CONCENTRATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE LISTENING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE COMPLETING WORK ON TIME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
JOB PERFORMANCE DIFFICULTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WASTING TIME ON THE COMPUTER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONCERN ABOUT MY CAREER CHOICE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GETTING ANGRY EASILY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANXIOUS IN SOCIAL SITUATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXPERIENCING PANIC SYMPTOMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UNABLE TO RELAX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBSESSIVE, INTRUSIVE, OR REPETITIVE THOUGHTS OR BEHAVIORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXPERIENCING DISCRIMINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEGAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EXPERIENCING EXTREME MOOD SWINGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEELING DOWN OR UNHAPPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEATH OR IMPENDING DEATH OF A SIGNIFICANT PERSON	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UPSET ABOUT END OF RELATIONSHIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USE OF ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USE OF ILLEGAL OR PRESCRIPTION DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USE OF CAFFEINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USE OF TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SELF-ESTEEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AMOUNT AND QUALITY OF MY SLEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EATING HABITS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DISSATISFIED WITH MY APPEARANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOW ENERGY/FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FINANCIAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICAL HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SELF-HARM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUSPICION OR PARANOID THOUGHTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HALLUCINATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RECENT CRISIS OR TRAUMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PAST OR CURRENT PHYSICAL OR SEXUAL ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THINKING ABOUT KILLING MYSELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THINKING ABOUT HARMING SOMEONE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER CONCERNS: _____			

YOUR PRIMARY REASON FOR SEEKING COUNSELING: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT LEVEL OF DISTRESS:**  
PLEASE CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR CURRENT LEVEL OF DISTRESS REGARDING YOUR CONCERNS:

**EMOTIONAL WELL-BEING**  
LOW 1 2 3 4 5 SEVERE

**OCCUPATIONAL PERFORMANCE/SATISFACTION**  
LOW 1 2 3 4 5 SEVERE

**SOCIAL RELATIONSHIPS/SOCIAL ACTIVITIES**  
LOW 1 2 3 4 5 SEVERE

**DAILY ROUTINE**  
LOW 1 2 3 4 5 SEVERE

PLEASE SIGN AND DATE TO INDICATE THAT YOU HAVE ANSWERED THE ABOVE QUESTIONS FULLY AND TRUTHFULLY TO THE BEST OF YOUR ABILITY:

PRINT NAME: \_\_\_\_\_

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_/\_\_/\_\_