# INTAKE FORM

**Today's Date:** ____/____/_____

## Personal Information

| | | | | |
|---|---|---|---|---|
| Name: | | | Age: | Sex: |
| Date of Birth: / / | | Race/Ethnic Group: | Home Phone #: ( ) -<br>Cell Phone #: ( ) - | |
| Address: | | | Marital Status: (please check one)<br>Never Married: ___<br>Married: ___<br>Divorced: ___<br>Widowed: ___<br>Separated: ___ | |
| City: | State: | Zip: | Message Phone #: ( ) - | |
| # of Children: | Their Ages: | | Home Phone #: ( ) - | |
| Emergency Contact Person: | | | Their Phone #: ( ) - | |

## Education / Employment Information

| | |
|---|---|
| Last grade completed in school: | Are you employed now? _____Yes _____No |
| Present Occupation: | Company Name: |
| Main occupation during past 5 years: | |

## Spiritual History

| | |
|---|---|
| Religious Affiliation: | Do you currently attend a place of worship?: |
| List a Few Words to Describe Your Personal Faith: | |
| List Those Who Support You Most Spiritually: | |

## General Information

How did you hear about us? _____

Problems you want help with:_____

_____

_____

How much have you worked during the past two years? _____

Describe your education (# of years of school, special training, etc.): _____

Describe any psychological problems you have or have had (e.g. periods of depression, anxiety, fears, phobias, problems with anger, confusion, etc.): _____

_____

Describe your living situation: _____

Did anyone in your family die before you were 18 years old? _____ Yes _____ No

Who? _____ How old were you? _____

Other family deaths? _____

When were you last examined by a physician? _____ Name _____

Present physician's name _____ Phone number _____

List any major health problems for which you have received treatment: _____

_____

Do you or your family members currently have or have ever had any of the following: (Please check all that apply)

| | SELF | FAMILY |
|---|---|---|
| HEART PROBLEMS | _____ | _____ |
| CANCER | _____ | _____ |
| NERVOUS BREAKDOWN | _____ | _____ |
| STROKE | _____ | _____ |
| CHRONIC ILLNESS _____ | _____ | _____ |
| ALCOHOL OR DRUG ABUSE | _____ | _____ |
| LEGAL PROBLEMS | _____ | _____ |
| LEARNING DISABILITY | _____ | _____ |
| DEPRESSION | _____ | _____ |
| OTHER _____ | _____ | _____ |

List any medications you are now taking (prescription and non-prescription): _____

| | | | | |
|---|---|---|---|---|
| Have you been abused or assaulted? | YES | NO | DON'T REMEMBER | (Circle One) |
| Did you witness abuse between your parents? | YES | NO | DON'T REMEMBER | (Circle One) |
| Did you witness abuse between parent and child? | YES | NO | DON'T REMEMBER | (Circle One) |

Have you ever received psychiatric or psychological help or counseling of any kind before?

YES _____ NO

If you have, please explain:_____

**List everyone currently living in your home, including family and other:**

| NAME | AGE | BIRTHDATE | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please circle any of the following which concern you:**

| | | | |
|---|---|---|---|
| NERVOUSNESS | DEPRESSION | FEARS | SHYNESS |
| SEXUAL PROBLEMS | SUICIDAL THOUGHT | SEPARATION | DIVORCE |
| FINANCES | ANGER | SELF-CONTROL | FRIENDS |
| SLEEP PROBLEMS | STRESS | WORK/SCHOOL | RELAXATION |
| HEADACHES | TIREDNESS | LEGAL MATTERS | MEMORY |
| AMBITION | ENERGY | INSOMNIA | MAKING DECISIONS |
| LONELINESS | INFERIORITY FEELINGS | CONCENTRATION | EDUCATION |
| CAREER CHOICES | MARRIAGE/RELATIONSHIPS | HEALTH PROBLEMS | TEMPER |
| NIGHTMARES | CHILDREN | EATING PROBLEMS | UNHAPPINESS |
| SEXUAL ABUSE | PHYSICAL ABUSE | BOWEL TROUBLES | BEING A PARENT |
| MY THOUGHTS | STOMACH PROBLEMS | GAMBLING | BINGE EATING |
| EATING TOO LITTLE | TOO HEAVY OR THIN | SPIRITUALITY | UNFORGIVENESS |

**Please circle any of the following strengths you have:**

| | | | | |
|---|---|---|---|---|
| CONFIDENT | HARD WORKER | ORGANIZED | SYMPATHETIC | GOOD LISTENER |
| DEPENDABLE | SENSITIVE | LOGICAL | LOYAL | GRACIOUS |
| DECISIVE | RESPONSIBLE | UNDERSTANDING | SENSE OF HUMOR | PATIENT |
| OTHER | | | | |

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

| | No, I Never Used | Yes, I Used | If yes, age at first use | When using, frequency of use (daily, weekly, etc.) | How long since last used? |
|---|---|---|---|---|---|
| Tobacco | | | | | |
| Alcohol | | | | | |
| Marijuana/Hashish | | | | | |
| Cocaine | | | | | |
| Crack | | | | | |
| Crank | | | | | |
| Meth/Amphetamine/Speed | | | | | |
| Hallucinogens (LSD, Mushrooms, Mescaline, etc.) | | | | | |
| Coffee | | | | | |
| Other | | | | | |

**Please add any additional information which you feel may be helpful to us:** _____

_____

_____

**THANK YOU FOR FILLING OUT THIS FORM**

_____

**Client's Signature**

_____

**Date**