INDIVIDUAL COUNSELING INTAKE SHEET

Who referred you to our center? _____
May we contact them? ____ Yes ____ No

CLIENT INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Address _____
Street City State Zip

Date of Birth _____ Age _____ Occupation _____Hours/Week _____

Contact phone:_____
May we leave messages on this phone? ____Yes ____No
May I send text messages to this phone? ___Yes ___ No
Email _____

Current Marital Status:
___ Never Married ___ Married ___ Engaged ___ Divorced ___ Separated ___Remarried
Name of Spouse (if applicable)_____
Date of Marriage _____
Date of Divorce (if applicable) _____ Date of Death (if applicable) _____

Previous Marital History (if applicable):
SELF:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____

Your Education Level: ___ GED ___ High School Diploma
___ College Degree ___ Graduate Degree Degree In _____

FAMILY INFORMATION

Name of other family members (Please indicate which members reside in your household):
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____

Please list a history of mental health issues in your family: _____
_____

PERSONAL INFORMATION

How would you rate your health? _____
How many hours do you sleep each night? _____
How would you rate your diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do you have addictive/abusive issues with: ___ Alcohol ___ Illegal Drugs ___ Prescriptions
___ Sex ___ Pornography ___ Gambling ___ Gaming ___ Other: _____
Has your appetite or weight changed lately? _____
Are you currently on medication? ____ Yes ____ No
If so, please complete the following:

Medication	Dosage	Physician	Purpose

Have you ever experienced mental, physical, emotion, or sexual abuse or neglect?
_____ Yes _____No
If, yes, please describe: _____

How have these issues been addressed?_____

Are you adopted?_____
Do you currently attend a church? ____ Yes ____ No
If yes, what is the name of the church? _____
Would you like spiritual matters to be part of your counseling? ____ Yes ____ No

PERSONAL CONCERNS

Briefly explain why you are coming to counseling and what you hope to gain from your experience. _____

What efforts have you or already made to address these concerns? _____

Have you been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

3. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2. I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3. No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4. I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5. Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6. I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7. I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8. I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9. I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10. I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11. I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12. God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13. I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14. Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15. I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16. People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17. I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18. Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
19. I hear voices in my head.	____ Never	____ Rarely	____ Sometimes	____ Frequently
20. I am out of control.	____ Never	____ Rarely	____ Sometimes	____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated	____	Lying	____
Mood swings (depression-manic)	____	Manipulation	____
Excessive guilt or shame	____	Poor impulse control	____
Loss of energy	____	Hyperactivity	____
Loss of interest in activities	____	Change or loss of friends	____
Suicidal thoughts	____	Sexual problems	____
Suicide attempts (how many)	____	Self-mutilation, cutting	____

Excessive stress	____	Work or school related problems	____
Anxiety or excessive fears	____	Hallucinations, delusions, thought distortions	____
Learning disabilities	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts/behaviors that occur frequently or are a concern to you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT
Whom should we contact in case of emergency?

Name _____
Address _____
Home Phone _____ Cell Phone _____