

COUNSELING INTAKE

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we call you and leave messages at home? Yes No

May we call you and leave messages at work? Yes No

May we send mail to you at this address? Yes No

Marital Status: S M D W Date of Current Marriage/Separation: _____ Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____ Age: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ Age: _____ M F

_____ Date of Birth: _____ Age: _____ M F

_____ Date of Birth: _____ Age: _____ M F

Previously Married? Yes No If yes, when? _____ How long? _____

Occupation: _____ Highest Level of Education: _____

MEDICAL HISTORY

How would you rate your current physical health? Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)? Yes No

If yes, please explain: _____

Previous hospitalizations for medical reasons Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

Please list any learning disabilities: _____

MEDICATION(S) Over-the-counter or prescription	DOSAGE

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? Yes No If yes, when? _____ Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

Have you ever been diagnosed with or treated for any type of mental illness? Yes No If yes, which type? _____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? Yes No If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

Where are your concerns causing the most problems for you? Please check all that apply:

- Home Work Marriage Other Relationships God

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others? _____

Please rate the severity of your present concerns on the following scale. Check one:

- Mild Moderate Severe Totally Incapacitating

Please indicate which of the following areas are currently problems for you. Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Feeling inferior to others | <input type="checkbox"/> Not being able to say what you really think or feel |
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Angry outbursts |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood | <input type="checkbox"/> Excessive fear of specific places or objects |
| <input type="checkbox"/> Excessive anxiety or worry | <input type="checkbox"/> Difficulty making friends |

- | | |
|---|---|
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Difficulty keeping friends |
| <input type="checkbox"/> Suspicious feelings toward other people | <input type="checkbox"/> Feeling as if you'd be better off dead |
| <input type="checkbox"/> Afraid of being on your own | <input type="checkbox"/> Feeling manipulated or controlled by others |
| <input type="checkbox"/> Angry feelings | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Concerns about finances | <input type="checkbox"/> Loss of interest in sexual relationships |
| <input type="checkbox"/> Feeling "numb" or cut off from emotions | <input type="checkbox"/> Feeling sexually attracted to members of your own sex |
| <input type="checkbox"/> Concerns about physical health | <input type="checkbox"/> Feeling distant from God |
| <input type="checkbox"/> Concerns about emotional stability | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Hypersomnia (sleeping all the time) |
| <input type="checkbox"/> Blackouts or temporary loss of memory | <input type="checkbox"/> Inability to concentrate while at school/work |
| <input type="checkbox"/> Insomnia (not being able to sleep) | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Loss of appetite/increased appetite | <input type="checkbox"/> Feeling "on top of the world" |
| <input type="checkbox"/> Uncontrollable anxiety or worry | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Lacking self-confidence | <input type="checkbox"/> Loss of interest in usual activities/lack of motivation |
| <input type="checkbox"/> Feeling fat | <input type="checkbox"/> Obsessions or compulsions with specific activities |
| <input type="checkbox"/> Eating and then vomiting to control weight | <input type="checkbox"/> Inability to control thoughts |
| <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Feeling trapped in rooms/buildings |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Getting into trouble at school/work | <input type="checkbox"/> Feeling that people are "out to get you" or that you are being watched |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Delusions |

What do you hope to gain from counseling? _____

Who can we thank for referring you to Daehnert Counseling LLP? Friend Church Pastor Other: _____

SPIRITUALITY

Do you believe in God? Yes No What is your religious preference? _____

Are you a member of a church? Yes No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? A lot A moderate amount A little None

EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____