

## 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: \_\_\_\_\_

<b>MEDICATION(S) Over-the-counter or prescription</b>	<b>DOSAGE</b>

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### **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? \_\_\_\_\_

<b>PSYCHIATRIC MEDICATION(S)</b>	<b>DOSAGE</b>

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### **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: \_\_\_\_\_

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## 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

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## EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_