DAEHNERT COUNSELING
Restoring Lives, Embracing Freedom

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:

- ❑ Feeling inferior to others
- ❑ Under too much pressure and feeling stressed
- ❑ Feeling down or unhappy/depressed mood
- ❑ Excessive anxiety or worry
- ❑ Feeling lonely
- ❑ Suspicious feelings toward other people
- ❑ Afraid of being on your own
- ❑ Not being able to say what you really think or feel
- ❑ Angry outbursts
- ❑ Excessive fear of specific places or objects
- ❑ Difficulty making friends
- ❑ Difficulty keeping friends
- ❑ Feeling as if you'd be better off dead
- ❑ Feeling manipulated or controlled by others

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