## Individual Intake

**Name**       Today’s Date

Address

City       State       Zip Code

Home Phone       Cell       Work

May we leave a voicemail on your home phone?  Yes  No On your cell phone?  Yes  No

Email Address:

Date of Birth:       Married?       Anniversary

Previous marriages?       How Many?       How long were their duration?

Are your parents divorced?       How old were you?       Did they remarry?

Do you have any siblings?       If so, how many?       Where are you in the birth order?

Is your family part of your support system?       Do they live in the local area?

Emergency Contact       Relationship

Phone (c)       E-mail

Please give the following information for each person that currently lives in your home, ***including yourself***.

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to Self |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please also list any other people in your immediate family who may not be living in your house:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to Self |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Personal and Medical Information: (please indicate whom)**

Are you currently taking any prescription medications?       If so, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Prescribed for |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Who is your prescribing doctor?       Phone #

List any other past or present medical issues:

Note any significant events occurring at this time (job loss, death in family, financial trouble):

Have you had thoughts of harming yourself or ending your life?       If yes, please describe (i.e. how long ago, did you have a plan)

**Family History (**please include **yourself** in this and specify **whom** it is in your family):

Alcoholism/Drug Abuse:

Depression, Manic/Depression, Schizophrenia:

Other mental illness:

Emotional, verbal, physical. sexual abuse:

Other significant childhood traumas:

**Other Back Ground Information:**

Do you currently attend church?       Do you have a role in church?

Which church do you attend?

Occupation?

Have you ever seen a therapist before?       If so, how long ago?

Was it helpful? How or how not?

**PRESENT CONCERNS:**

|  |  |
| --- | --- |
| Abuse (sexual, emotional, physical)  Addiction/Substance abuse  Alcohol  Gambling  Tobacco  Prescription Medications  Other  Aggression, violence  Alcohol use  Anger, hostility, arguing, irritability  Anxiety, nervousness  Attention, concentration, distractibility  Career concerns, goals, and choices  Children, childcare, parenting  Codependence – unhealthy attachments  Confusion  Compulsions, addictions  Decision-making, indecision, mixed feelings,  putting off decisions  Delusions (false ideas)  Depression, low mood, sadness, crying  Divorce, separation  Eating problems—overeating, under eating,  appetite, vomiting  Fatigue, tiredness, low energy  Fears, phobias  Financial or money troubles, debt, impulsive  spending, low income  Friendships  Grieving, mourning, deaths, losses, divorce  Guilt  Health, illness, medical concerns, physical  problems | Inferiority feelings  Interpersonal conflicts  Internet Addiction  Impulsiveness  Legal matters, charges, suits  Loneliness  Marital conflict, distance / coldness, infidelity  affairs, remarriage  Memory problems  Mood swings  Motivation, laziness  Nervousness, tension  Obsessions, compulsions (thoughts or actions that  repeat themselves)  Panic or anxiety attacks  Perfectionism  Pessimism  Pornography use  Procrastination, work inhibitions, laziness  Relationship problems  School problems  Self-esteem  Self-neglect, poor self-care  Sexual issues, dysfunctions, conflicts, desire  differences  Sleep problems—too much, too little, insomnia,  and nightmares  Smoking and tobacco use  Stress, relaxation, stress management  Suspiciousness  Thought disorganization and confusion  Work problems employment, workaholism/  overworking, can't keep a job |

Any other concerns not listed above:

What brings you here today for counseling?

1.

2.

3.

4.

5.

**TREATMENT PLANNING:**

What are your goals for counseling?

1.

2.

3.

4.

5.

6.

Additional treatment goals if applicable (for office use only):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you would like us to know about you?

How did you hear about One:12 Counseling?

**Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_**