## 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.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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