Developing Insights

Intake Form

Instructions: Please Fill Out Form As Best As Possible and Return to Therapist Before First Session. Click Checkbox to Mark Your Choice. Intake Form Will Be Reviewed In First Session.

Date of intake (For Therapist Use Only): _____ **Therapist:** _____

Date : _____

New client: ☐**Yes /**☐ **No** **Transfer client:** ☐**Yes /** ☐**No** **Returning client:** ☐**Yes /** ☐**No**

Referral source: _____

Demographic information

Client name: _____

Address (city, state, zip.Postal Code/Country): _____

Primary phone (☐**c /** ☐**h/** ☐**w):** _____ **Secondary phone (**☐**c/** ☐**h/** ☐**w):** _____

OK to leave message: ☐**Y/**☐**N Primary phone:** ☐**Yes /** ☐**No** **Secondary phone:** ☐**Yes /** ☐**No**

Age: _____ **Date of birth:** _____

How would you identify your sexual orientation? _____ **Which gender do you identify as?** _____

Cultural identity: _____ **Adopted:** ☐**Yes /** ☐**No** **If Yes, At What Age:** _____

Occupation: _____ **Job satisfaction:** _____

Place of employment: _____ **Length of employment:** _____

Marital status: ☐**Married** ☐**Committed** ☐**Single** ☐**Divorced** ☐**Widowed** **Other** _____

Spouse/significant other: Name: _____ **Age:** _____ **Length of relationship:** _____

Person to notify in case of emergency: _____

Phone: _____ **Relationship:** _____

Originally From (City/State or Country): _____

Parental Information

Parents: Father Alive? ☐**Y/**☐**N Mother Alive?** ☐**Y/**☐**N or If Raised By Someone Other Than Your Birth Parents:**

_____

Parental Relationship: ☐**Married** ☐**Committed** ☐ **Divorced If Divorced, When:** _____

Is either Parent in a New Relationship: ☐**Y/**☐**N If Yes, details:** _____

_____

Education

Highest level of education: _____ If a student, name of school: _____

Grade point average and/or major: _____

Any problems related to school: _____

Military

Military service: ☐Yes /☐ No Branch: _____ Dates of Service: _____

Any problems related? : _____ Active duty?: ☐Yes / ☐No

Have you/will you deploy? ☐Yes / ☐No If so, for how long and when?: _____

Leisure/recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc.)

Activity: How often currently? How often in the past?

_____

_____

_____

_____

Medical history

Current health/medical problems: _____

_____

Are you being treated for the above/any of the above health/medical problems? ☐Yes / ☐No

If so, please explain: _____

Are you under the care of a physician or specialist? ☐Yes / ☐No

Date of last physical exam: _____

Name, address, phone of primary physician: _____

_____

List previous illnesses, surgeries, accidents, and operations (include dates): _____

_____

List any prescribed and/or over the counter medication for medical issues? (name, dose, and reason for the medicine):

_____

_____

Allergies: _____

Do you smoke? ☐**Yes /** ☐**No** **How much per day?** _____

Do you drink? ☐**Yes /**☐ **No** **How much does it take for you to feel drunk?** _____

PERSONAL HISTORY

Currently experiencing:

☐**Anger issues** ☐**Anxiety** ☐**Coping issues** ☐**Depression** ☐**Eating disorder**

☐**Fear/phobias** ☐**Sexual concerns** ☐**Behavioral issue** ☐**Grief** ☐**Sleeping problems**

☐**Addiction issues** ☐**Alcohol/drugs** ☐**Obsession** ☐**Compulsion** ☐**Abuse issues**

☐**Gender identity issues** ☐**School/work related issues** ☐**Pressure**

☐ **Other:** _____

If any of the above is checked, please explain: _____

_____

_____

Are you currently under the care of a *mental health* professional? ☐**Yes /** ☐**No**

List name, address, and phone of *mental health* professional: _____

_____

History of psychiatric issues: _____

_____

_____

List any prescribed medication for psychiatric purposes (name, dose, and reason for the medicine): _____

_____

_____

Previous counseling experiences (rehabilitation, psychiatric, hospitalizations)

Beginning and ending year: **Where:** **With whom:** **Presenting issues:**

_____

_____

_____

_____

_____

What was helpful or unhelpful about these experiences? _____

_____

_____

_____

History of abuse (verbal, emotional, sexual, physical)

Verbal: _____

Emotional: _____

Sexual: _____

Physical: _____

Legal history

Prior arrests: _____

Prior charges: _____

Incarcerations: _____

Alcohol and/or drug use history

Substance: **When started:** **How much/often:** **Last use:**

_____

_____

_____

_____

Issues resulting from drug/alcohol use (e.g. relationships, health, work, school, etc.): _____

_____

_____

_____

_____

FAMILY HISTORY

Family of origin (parents, siblings)

Name: **Living/Deceased/Year Of Death:** **Age:** **Relationship to person:** **Quality of relationship:**

_____

_____

_____

_____

_____

Current family (including children)

Name: **Age:** **Relationship to person:** **Quality of relationship:**

_____

_____

_____

_____

_____

Other significant relationships (best friends, neighbors, pets)

Name: **Age:** **Relationship to person:** **Quality of Relationship:**

_____

_____

_____

_____

Family history of abuse (verbal, emotional, sexual, physical)

Verbal: _____

Emotional: N/A_____

Sexual: _____

Physical: _____

Family history of substance abuse

Name: **Relationship:** **Substance:** **When started:** **How much/often:** **Last use:**

_____

_____

_____

_____

Family history of psychiatric issues

Name: **Relationship:** **Psychiatric Diagnoses:**

_____

_____

_____

_____

Family history of medical issues

Name: **Relationship:** **Medical Diagnosis:**

_____

_____

_____

_____

Family/Significant other legal history and circumstances:

Prior arrests:_____

Prior charges: _____

Incarcerations: _____

SUICIDE / HOMICIDE ASSESSMENT (For Therapist Use Only)

	Y	N	Uncertain	DESCRIBE
CURRENT SUICIDAL IDEATION (SUICIDAL THOUGHTS)	☐	☐	☐	
CURRENT SUICIDAL PLAN	☐	☐	☐	
CURRENT MEANS FOR COMPLETING THE PLAN	☐	☐	☐	
PAST HISTORY OF SUICIDAL IDEATION	☐	☐	☐	
PAST HISTORY OF SUICIDAL ATTEMPTS	☐	☐	☐	
CURRENT HOMICIDAL IDEATION	☐	☐	☐	
CURRENT MEANS FOR COMPLETING HOMICIDAL PLAN	☐	☐	☐	
PAST HISTORY OF HOMICIDAL IDEATION	☐	☐	☐	
CURRENT AND PAST HISTORY OF VIOLENT BEHAVIOR TOWARDS PEOPLE	☐	☐	☐	
CURRENT AND PAST HISTORY OF VIOLENT BEHAVIOR TOWARDS ANIMALS	☐	☐	☐	
WHEN YOU GET ANGRY, DO YOU THROW/DESTROY OBJECTS?	☐	☐	☐	

Presenting issue(s): _____

_____

_____

Reason for seeking counseling: _____

_____

_____

Client perceives own strengths as: _____

_____

_____

Client perceives own areas of improvement as:

_____

_____

Client's goals for counseling are as follows: _____

_____

_____

_____ _____

Counselor's signature **Date**