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Personal Intake Assessment

Please fill in the information below and bring it with you to your first session. Information you provide is confidential and will not be released without your consent. If certain items do not apply to you, please leave them blank.

1) Name: _____ 2) Age: _____ 3) Sex: M _____ F _____
4) Address: _____
(Street) (City) (State) (Zip)

5) Today's Date: ____ - ____ - ____ 6) Date of Birth: ____ - ____ - ____
7) Years of Education: _____ 8) Occupation: _____

9) Current **Relationship** Status (check any that apply):

Married/Partnered _____Yrs. _____ Mos. Dating: How long? _____ Yrs. ____Mos.

Single: How long? _____Yrs. _____ Mos.

a) Do you have Children together? Y or N - or - Children from Prior Rels. /Marriages? Y or N

What are the Ages of YOUR children now (use B or G plus age, ex. B10, G8)?

_____?

b) How Many People Live in Your Home Currently? _____?

10) **IF Married** or **Partnered**,

- IF you are **MARRIED**, for **how long?** _____ Yrs. ____ Mos.
- HOW LONG HAVE YOU BEEN IN your relationship? _____ Yrs. ____ Mos.
- DO YOU LIVE WITH your SPOUSE/PARTNER? _____ Yrs. ____ Mos.

12) I was **CHILD NUMBE**R _____ of _____ children. **Ex. "I was 3 of 6 children."**

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13) **First** Name, Gender, and Age **of YOUR SIBLINGS (including YOU and YOUR current age)**:

1._____ 5. _____

2._____ 6. _____

3._____ 7. _____

4._____ 8. _____

Counseling History

14) Are you **presently** receiving other counseling services? _____ Yrs. ____ Mos.

If YES, *please briefly describe*: _____

_____

_____

15) Have you received **COUNSELING IN THE PAST**? _____ Yrs. ____ Mos.

If yes, please briefly describe:_____

_____

_____

16) What is your **MAIN REASON** for coming to counseling? _____

_____

_____

_____

_____

What has occurred ***recently*** that led to your decision to get counseling now?

_____

_____

_____

_____

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Compulsive Behaviors & Substance USE and/or ABUSE History

17) Are you **Currently** working on limiting *certain* compulsive behaviors, **or** do you have a **HISTORY** of **multiple** Compulsive Behavior(s) or Addiction(s)? ____ Yes ____ No

Please note any that apply:

ALCOHOL (Abuse or Dependence): _____

*How many drinks per nights (**avg**.)?* _____ *How many nights per week (on **avg**.)?* _____

MOOD ALTERING CHEMICALS (Abuse or Dependence), **Substance(s) of choice?** _____

_____

Compulsive GAMBLING: _____

Compulsive SPENDING: _____

Compulsive WORK: _____

Compulsive EATING: _____

Most **recent** or **common** issues with FOOD and/or prior **diagnosis** of an Eating Disorder?

_____

Other compulsive behavior(s): _____?

Family History

18) **Mother's AGE**: _____ If deceased, how old were **YOU** **when** she passed? _____

19) **Father's AGE**: _____ If deceased, how old were **YOU** **when** he passed? _____

20) **If** your parents are separated or divorced, **HOW OLD WERE YOU** at the time? _____

21) Were you **ADOPTED** or raised with parents other than your natural parents? ____ Yes ____ No

22) Which of the following **BEST DESCRIBES** the family in which you grew up?

Warm /Accepting ***Average*** ***Hostile / Fighting***

1 2 3 4 5 6 7 8 9 10

23) Which of these describes the way in which your family raised you?

Permissive* Parenting** ***Average ***Controlling / Punitive***

1 2 3 4 5 6 7 8 9 10

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Your Mother, Stepmother or Substitute Mother

24) **5 WORDS** that best **Describe** your Mother: _____
_____
_____
_____

25) How did she **Discipline** you? _____
_____
_____
_____

26) How did she **Reward** you? _____
_____
_____

27) How much **TIME** did she spend with you when you were a child?

Much **Average** **Little**

28) Your mother's employment when you were a child? _____

Stayed home **Worked outside part-time** **Worked outside full-time**

29) **Did your MOTHER have specific struggles or problems** (ex. alcoholism, depression/anxiety, anger/rage issues, etc.) which may have impacted you as a child? ____ Yes ____ No

If yes, please describe: _____
_____
_____
_____

Your FATHER, Stepfather or Substitute Father

30) **5 WORDS** that best DESCRIBE your Father: _____
_____
_____
_____

31) How did he **Discipline** you? _____
_____
_____
_____

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32) How did he **Reward** you? _____
_____

33) How much **TIME** did he spend with you when you were a child?

Much **Average** **Little**

34) Your **FATHER'S** employment when you were a child? _____

Stayed home **Worked outside part-time** **Worked outside full-time**

35) **Did your Father have specific struggles or problems** (ex. alcoholism, mood, anger/rage/violence issues, etc.) which may have affected you as a child? ____ Yes _____ No

If yes, please describe: _____
_____
_____
_____

Religion / Spirituality

36) Do you identify with any of these Religious Affiliations?

Christian (specify) _____
Jewish
Muslim
Buddhist
None, *but I believe in* ...God
Agnostic (uncertain of belief)
Atheist
Other (please specify) _____

37) How important is religious or spiritual commitment to you **currently**?

Unimportant **Average** **Extremely Important**

1 2 3 4 5 6 7 8 9 10

Medical History

38) Name and phone number of your Primary Physician: _____
_____

39) List any **major illnesses** and/or operations you have had or have: _____
_____
_____

40) When was your last complete physical exam? _____

Results of physical exam? _____

41) What **Medication**(s) do you take currently and **for what purpose** (please include psychiatric meds)? _____

_____

_____

41b) Who prescribes you **Psychiatric Medications**? Name and phone of prescriber?

_____

_____

42) Do you have problems with Seep? ____ Yes ___ No

43) Have you experienced any **injuries to your head** (ex. Concussion)? If yes, have you had more than one? ____ Yes _____ No **Type(s) of Injury**: _____

How many such injuries have you had in your *lifetime*? _____

_____

44) Do suffer from **Chronic Pain**? Is your pain currently managed effectively? _____

_____

45) Have Physical or Medical problems contributed to your decision to seek treatment now? _____

_____

Support Environment

46) **Who do you depend on** for emotional support? **Parent(s)?** ☐ **Partner?** ☐ **Friend(s)?** ☐ **Other supports?** ☐ **Church Community?** ☐ **12-Step Community?** ☐ **Work Colleagues?** ☐

47) Do you have a group of **friends outside of your family?** ____ Yes _____ No

48) What do you do for fun? _____

Thoughts and Behaviors

49) Please check how often the following thoughts occur to you:

• Life is hopeless	Never	Rarely	Sometimes	Frequently
• I am lonely	Never	Rarely	Sometimes	Frequently
• No one cares about me	Never	Rarely	Sometimes	Frequently
• I am a failure	Never	Rarely	Sometimes	Frequently
• Most people don't like me	Never	Rarely	Sometimes	Frequently
• I want to die	Never	Rarely	Sometimes	Frequently
• I want to hurt someone	Never	Rarely	Sometimes	Frequently
• I am so stupid	Never	Rarely	Sometimes	Frequently
• I am going crazy	Never	Rarely	Sometimes	Frequently
• I can't concentrate	Never	Rarely	Sometimes	Frequently
• I am so depressed	Never	Rarely	Sometimes	Frequently
• God is disappointed in me	Never	Rarely	Sometimes	Frequently
• I can't be forgiven	Never	Rarely	Sometimes	Frequently
• Why am I so different?	Never	Rarely	Sometimes	Frequently
• I can't do anything right	Never	Rarely	Sometimes	Frequently
• People hear my thoughts	Never	Rarely	Sometimes	Frequently
• I have no emotions	Never	Rarely	Sometimes	Frequently
• Someone is watching me	Never	Rarely	Sometimes	Frequently
• I hear voices in my head	Never	Rarely	Sometimes	Frequently
• I am out of control	Never	Rarely	Sometimes	Frequently

Please note other important details (e.g., examples, frequency, duration, the impact the statement might have on your sense of well-being) about EACH THOUGHT that occurs FREQUENTLY. **If needed, please use the back of this sheet.**

Symptoms

50) Check any **behaviors or symptoms** you have that occur more often than you would like.

Aggression	Dizziness	Irritability	Sleeping problems
Alcohol dependence	Drug dependence	Judgment errors	Speech problems
Anger	Eating disorder	Loneliness	Suicidal thoughts
Antisocial behavior	Elevated mood	Memory impairment	Thoughts disorganized
Anxiety	Fatigue	Mood shifts	Trembling
Avoiding people	Hallucinations	Panic attacks	Withdrawing
Chest pain	Heart palpitations	Phobias/fears	Worrying
Depression	High blood pressure	Recurring thoughts	Other (specify): _____
Disorientation	Hopelessness	Sexual difficulties	_____
Distractibility	Impulsiveness	Sick often	_____

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51) Are you currently involved in the **Legal System**? ____ Yes ____ No

If yes, please explain: _____

_____

_____

52) **Have you ever been treated in a Residential setting for mental health reasons?** Include rehab programs for substance abuse, alcohol abuse, and/or compulsive behaviors. ___ Yes __ No

If yes, please explain: _____

_____

53) Are you aware of any **Family History of Mental Illness?**

_____

_____

_____

_____

Thank you for taking the time to complete this assessment! The information you shared helps your counselor develop an informed plan that can serve as a "roadmap" to achieving the goals you set for yourself in therapy.