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# CONFIDENTIAL INTAKE FORM

## Please print, fill out, and mail to PO Box 2745 Rancho Santa Fe, CA 92067

**Name: ____________________________________ Age:________**

**Date of Birth:____________**

**Gender:**

Male

Female

Transgender

**Home Address: _____________________________________________________________________**

**Mailing Address if different than Home:________________________________________________**

**Email Address:____________________________________________ May we email you Yes No**

**Best Contact Phone number: _________________________________**

**Emergency Contact Name ___________________ Relationship _______________ Phone__________**

**PROBLEM ANALYSIS:**

**Briefly describe the problem you most wish help with right now:**

**How would you rate the intensity of the problem or concern that brought you in?** (Circle the appropriate number):

**1 2 3 4 5 6**

***Not Intense***

***Moderately Intense***

***Extremely Intense***

**How much has your current problem interfered with your life in general?**

Not at all A little Somewhat

Moderately Too a great extent

**In what ways have you attempted to cope with this problem?**

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**SOCIOCULTURAL BACKGROUND:**

**Racial/Ethnic Background:**

White/Caucasian African-American Black African Asian-American Asian or Pacific Islander

Hispanic-American Latino/Latin American/Hispanic

Arab-/Middle Eastern-American Arab/Middle

Eastern

Native American/Alaskan Native Multiracial / Other

**Specify**:_______________________________________________________________________

**How much do you identify with your ethnic heritage?**

Not at all A little Somewhat

Moderately Strongly

**Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list:**

________________________________________________________________________

**Religious preference: _____________________________ Are your currently active in your religion?**

Yes Somewhat No

**Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process?**

Yes No I Don't Know

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## ACADEMIC/ WORK BACKGROUND:

**Place of employment: ______________________________________________**

**Hours worked per week: ___________ Years with employer: _______________**

**Position: ____________________________________________**

**Are you satisfied with your job? Yes No I Don't Know**

**Highest Educational Degree: ________________________________**

**Major: _________________________________________**

**Are you a student?** Y N **If yes, where are you studying: ________________________**

## RELATIONAL/ SUPPORT HISTORY:

**Please indicate your current relationship status:**

Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed

Other:_______________________

**Approximately how many significant romantic relationships have you had? __________**

**If you are in a romantic relationship, how long have you been in this relationship? __________**

**Are you satisfied with your current romantic relationship?**

Yes No I Don't Know

**Do you feel supported by your partner/spouse? ?** Yes No I Don't Know

**How would you rate the quality of your friendships?**

Very Poor Unsatisfactory About Average Good Excellent

**Besides family, how many people can you count on right now for friendship/emotional support? ____**

## FAMILY BACKGROUND:

**Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student,12; partner, M, doctor, 35):**

**Family Member**

**Occupation**

**Age**

**Your Family's Religious/Spiritual Background: ____________________________________________**

**How much conflict do you currently experience with your family? (whether living with you or not)**

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Very little or none Some Moderate Strong Extreme

**Who in your family do you currently feel closest to?** _________________________________

**Most distant from?** _____________________ **In most conflict with?** ____________________

## PHYSICAL HEALTH:

**How is your physical health at present?**

Poor Unsatisfactory

Satisfactory

Good

Very good

**When was your last physical examination?** ___________________________________________

**Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):**

**Do you have a disability ?** No Yes **Specify**

____________________________________________________________

**Are you presently taking any prescribed medication ?**

Yes No

**Please list all medications, the reason for which each is prescribed, name of prescribing physician (ie. Paxil/ social anxiety/Dr. Joseph):**

________________________________________________________________________________________

_______________________________________________________________________________________

**Name of your primary care physician:**

________________________________________________________________________

**Are you having any problems with your sleep habits?** No Yes

**Are you having any difficulty with appetite or eating habits**? No Yes

**Have you had a significant weight change in the last 2 months?** No Yes

**Do you have any problems or worries about sexual functioning?**

No

Yes**How many times per week do you exercise?** __________ **For how long each time?** ___________

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**MENTAL HEALTH HISTORY:**

**Have you ever been a victim of:** *(if you do not feel comfortable completing this section, simply leave it blank or write prefer to discuss)*

Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child

Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse

Sexual abuse/assault as an adult Other Trauma **Specify**:_________________________________________

**Have you received counseling elsewhere before?** Yes No

**If yes, where:** ________________________

**When:** __________________

**Duration:** ___________

**What was the focus of previous counseling?**

_________________________________________________________________

**Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past?** Yes No

**If yes, where:** ________________________

**When:** ___________________

**Duration:** __________

**What was the focus of the psychiatric treatment?**

_________________________________________________ ____________

**Were you EVER prescribed psychiatric medications?** Yes No

**What medications and for what reason?**

______________________________________________________________________________________

**How often are you having suicidal thoughts presently?**

Frequently

Sometimes

Rarely

Never

**How often have you had suicidal thoughts in the past?**

Frequently

Sometimes

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Rarely

Never

**When:** ________________________________________

**How often are you having thoughts of harming others presently?**

Frequently

Sometimes

Rarely

Never

**How often have you had thoughts of harming others in the past?**

Frequently

Sometimes

Rarely

Never

**When:** ________________________________________

**Have you ever intentionally inflicted any harm upon yourself?**

Yes

No

Unsure

**When:** ________________________________________

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**Have you ever attempted suicide?** Yes No

**Date(s)**

____________________________________________________________

**Have you ever been hospitalized for psychological reasons?**

Yes

No

**Date(s)** ______________________________________________________

**ALCOHOL AND OTHER DRUG USE:**

**How often do you drink alcohol?**

Daily 3 or more times per week

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1-2 times per week

Weekly

Monthly

Less than monthly Never

**In a typical week, on how many days do you have 4 or more drinks? __________**

**How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?**

Daily

3 or more times per week

1-2 times per week

Weekly

Monthly

Less than monthly Never

**Do you or does someone else think that you may need to cut down or stop using other drugs?**

Yes

No

Maybe

**How many counseling sessions do you anticipate needing?**

1-3

4-6

7-9

10-12

13-15

16-20

20+

**How motivated are you to resolve this problem?**

Not at all

A little Somewhat

Moderately Extremely

**Why have you decided that now is the time in your life to take action to resolve this problem?**

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**How hopeful are you that this problem can be resolved?**

Not at all

A little Somewhat

Moderately Extremely

**List your strengths and qualities you admire about yourself:**

When our work together has been successful, what differences will you notice in yourself?

**SIGNATURE:**

I verify that the above information is accurate to the best of my knowledge.

_____________________________

______________________________

________________

Client Name

Client Signature

Date

Reference:

Acessed January 29, 2009, Google: Intake Form; **www.LifeSkillsResourceGroup.com cfabico@LifeSkillsResourceGroup.com**