Individual Intake Form

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In order to help your therapist provide the best care, please complete this form. If you are not sure about any item, or feel uncomfortable answering, please leave that part blank. Answer what you are able, and speak with your therapist about any area of concern.

How did you hear about Friends of the Family? ______________________________

PERSONAL INFORMATION **TODAY'S DATE:** ____________

Name		Age:	Birth date:
Mailing Address City, State, Zip			
Email		Contact me by email?	YES NO
Home phone		Contact me at my home phone?	YES NO
Cell phone		Contact me by cell phone?	YES NO
Vocation(s)			
Job Title(s)			
Employed by			

Please describe your reason for seeking counseling. ______________________________

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What do you hope to gain from counseling? ______________________________

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Please describe any previous counseling experience(s). ______________________________

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Religious Affiliation ______________________ Involvement: ☐ Active ☐ Somewhat active ☐ Inactive

What are your religious beliefs? ______________________________

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What spiritual tradition were you raised in, if any? ______________________________

How do your current spiritual beliefs help you during problematic times in your life? ______________________________

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Please indicate your go-to sources for **Emotional or Social Support** (E.G., Church, Social Events, Family, Work, Hobbies, Clubs, etc.): ____________

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 CLIENT NAME: **TODAY'S DATE:**

Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Long term relationship

How long has this been your relationship status? ____________________

If in a committed relationship, how would you describe your relationship? ____________________

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Description of Household:

Name	Age	Relationship
Other immediate family members NOT living at home		

If you have **children**, how would you describe your relationship with them? ____________________

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Please describe any **Major Traumas** you have experienced (sudden loss of child or loved one, military combat, feared death experiences, etc.)

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Medical Information:

Name of Primary Physician ____________________ Phone ____________________ Date of last visit ____________________

Do you have a **mental health** diagnosis? If so, what is it and when was it diagnosed? ____________________

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Please list all Current Medications:

Name of Medication	Dosage	Times per day (am/pm)	Physician	Reason for

CURRENT CLIENT SYMPTOMS: Please rate ALL from 1-3 (**1**-no/low concern, **2**-moderate concern, **3**-high concern)

☐ Family problems	☐ Feel sad or depressed	☐ Anxiety / worry	☐ Hear strange things
☐ Marital / relationship issues	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors / feelings	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health problems	☐ Legal problems
☐ Employment changes	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless / Can't sit still
☐ Feel lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating disorder	☐ Other:

Please briefly explain any 2/3 level concerns: ____

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Problems that occurred in the <u>HOUSEHOLD(S)</u> in which you were raised <u>BEFORE THE AGE OF 18</u>:

	Alcohol / drug addiction		Physical abuse		Emotional / verbal abuse		Unwanted touching
	Financial problems		Sexual abuse		Divorce		Lived in foster home
	Emotional distance		Pornography				

Problems that occurred <u>TO YOU BEFORE THE AGE OF 18</u>:

	Alcohol / drug addiction		Physical abuse		Emotional / verbal abuse		Unwanted touching
	Financial problems		Sexual abuse		Divorce		Lived in foster home
	Emotional distance		Pornography		Developmental problems		Learning disability

On the following checklists, please mark (√) the problems that are a concern to you.

√	Concerns about YOURSELF	√	Concerns about YOUR PARTNER	√	Concerns about YOUR RELATIONSHIP	√	Concerns about your CHILDREN / FAMILY
	Chronic illness / pain		Chronic illness / pain		Poor Communication		Stealing
	Depression		Depression		Argue about finances		Destructive Behaviors
	Anxiety / worries / stress		Anxiety / worries / stress		Not enough time together		Truancy
	Eating disorder		Eating disorder		Excessive alcohol / drugs		Adolescent pregnancy
	Relationship problems		Relationship problems		Pornography		Sexual abuse (victim)
	Grief		Grief		Refuses sex too often		Sexual abuser
	Self-esteem		Self-esteem		Demands sex too often		Disobedience
	Lack of assertiveness		Lack of assertiveness		Inappropriate sexual behavior		Divorce adjustment
	Suicidal thoughts		Suicidal thoughts		Physical sexual problems		Death in family
	Self-injury / self-mutilation		Self-injury / self-mutilation		Fighting / arguing		Anger / Fighting
	Anger		Anger		Parenting issues		Drugs / alcohol
	Sexual addiction		Sexual addiction		Partner too controlling		Peer relationships
	Sexual abuse / rape		Sexual abuse / rape		Physical violence		Bed-wetting / soiling
	Emotional abuse		Emotional abuse		Difficulties with in-laws / family		Poor self-esteem
	Physical abuse		Physical abuse		Different values		Issues with stepchildren
	Other:		Other:		Other:		Other:

Understanding your "family system" can be very helpful in getting to the root of problems or concerns that you are facing. To the best of your knowledge, please mark (√) where appropriate and give any details you know.

History of...	Self	Spouse	Immediate Family	Extended Family	Details
Significant medical concerns					
Mental health concerns					
Military service					
Abuse					
Alcohol / Drug use					
Alcohol / Drug misuse					
Addictions					
Pornography use					
Affair(s)					
Trouble with the law					
Divorce / Separation					
Other:					

Any other situation, experience, or concern your therapist should be aware of? ______________________________

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