

# FAMILY & CHILD DEVELOPMENT

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## Individual Intake Form

*Thank you for taking the time to complete this intake form. Please note that the information you provide here is protected as confidential information. Please complete all items if possible. If you have any questions, please ask.*

### I. IDENTIFICATION

Your Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Spouse/Partner: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Marital status (please circle one):

Married

Never Married

Separated

Divorced

List child(ren) and ages: \_\_\_\_\_

\_\_\_\_\_

Home address: \_\_\_\_\_

Street

City

State

Zip Code

Home phone number: \_\_\_\_\_ May we leave a message? \_\_\_\_\_ Yes \_\_\_\_\_

No

Cell: \_\_\_\_\_ May we leave a message? \_\_\_\_\_ Yes \_\_\_\_\_ No

Email address: \_\_\_\_\_ May we email you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by (if applicable): \_\_\_\_\_

### II. PRESENTING PROBLEM(S)

Please give a description of the presenting problem or major complaint that brings you in here today:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Please give a brief description of the history of the problem and how you have tried to handle it. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What specifically do you expect your counselor to do to help you with your concern? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### III. YOUR MENTAL HEALTH HISTORY

Have you previously received any mental health or substance abuse services? \_\_\_\_ Yes \_\_\_\_ NO

Date	Facility	Inpatient/Outpatient	Diagnosis

What do you consider to be the top three stressors in your life?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

#### Psychological Symptoms

**Emotions:** Select any of the following that you find troubling and/or applied to you in the last month.

- |                  |                       |                   |
|------------------|-----------------------|-------------------|
| ____ Anxious     | ____ Easily excitable | ____ Lonely       |
| ____ Angry       | ____ Fearful          | ____ Relaxed      |
| ____ Bored       | ____ Frustrated       | ____ Restless     |
| ____ Confused    | ____ Guilty           | ____ Sad          |
| ____ Contented   | ____ Happy            | ____ Suspicious   |
| ____ Distrustful | ____ Hopeless         | ____ Tense        |
| ____ Energetic   | ____ Jealous          | ____ Other: _____ |

**Behaviors:** Select any of the following that you find troubling and/or applied to you in the last month.

- |                          |                     |                      |
|--------------------------|---------------------|----------------------|
| ____ Aggression          | ____ Hurting self   | ____ Oversleeping    |
| ____ Attention problems  | ____ Hurting others | ____ Risk taking     |
| ____ Avoiding activities | ____ Impulsiveness  | ____ Spending sprees |

<input type="checkbox"/> Avoiding/people/places	<input type="checkbox"/> Increased drinking	<input type="checkbox"/> Taking mood altering drugs
<input type="checkbox"/> Concentration problems	<input type="checkbox"/> Increased energy	<input type="checkbox"/> Temper outbursts
<input type="checkbox"/> Crying	<input type="checkbox"/> Increased smoking	<input type="checkbox"/> Under eating
<input type="checkbox"/> Decreased energy	<input type="checkbox"/> Isolation	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Decreased interests	<input type="checkbox"/> Loss of control	<input type="checkbox"/> Under sleeping
<input type="checkbox"/> Employment difficulty	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Fearful
<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Overeating	<input type="checkbox"/> Other: _____

Do you drink alcohol?  YES  NO If yes, how much each time? \_\_\_\_\_

How often do you engage in recreational drug use? (circle one please)

Daily                  Weekly                  Monthly                  Occasionally                  Never

Are you experiencing overwhelming grief or depression?  YES  NO; for how long? \_\_\_\_\_

Are you experiencing anxiety, panic attacks or phobias?  YES  NO; for how long? \_\_\_\_\_

Do you feel you would be better off dead?  YES  NO

Have you ever attempted suicide?  YES  NO; If yes, what were the circumstances? \_\_\_\_\_

**IV. FAMILY MENTAL HEALTH HISTORY**

*Is there a family history of any of the following? Please indicate which family members may have experienced any of the following.*

Alcoholism (who and for how long?): \_\_\_\_\_

\_\_\_\_\_

Substance abuse (who and for how long?): \_\_\_\_\_

\_\_\_\_\_

Mental Illness (who and what diagnosis?): \_\_\_\_\_

\_\_\_\_\_

Serious Illness or Hospitalizations (who and for how long): \_\_\_\_\_

\_\_\_\_\_

Is there any history of physical, emotional, verbal, or sexual abuse?  Yes  No

Please list victims, including yourself. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**V. MEDICAL HISTORY**

*Your medical information is used to detect possible medical conditions that may require a physician's attention. This may result in a recommendation that you consult with your physician for further examination.*

Your Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current medications and dosage: \_\_\_\_\_

Past medications: \_\_\_\_\_

\_\_\_\_\_

**Symptom Checklist**

**Please check the symptoms or conditions that have applied to you at any time.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alcoholism      | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Head trauma         | <input type="checkbox"/> Liver disease  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> Cancer/tumors   | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Smoking        |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> High blood pressure |   |

**Please check the symptoms or conditions that frequently apply to you.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Sexual problems            |
| <input type="checkbox"/> Attention problems     | <input type="checkbox"/> Hurting others     | <input type="checkbox"/> Risk taking                |
| <input type="checkbox"/> Avoiding activities    | <input type="checkbox"/> Impulsiveness      | <input type="checkbox"/> Spending sprees            |
| <input type="checkbox"/> Avoiding/people/places | <input type="checkbox"/> Increased drinking | <input type="checkbox"/> Taking mood altering drugs |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Increased energy   | <input type="checkbox"/> Temper outbursts           |
| <input type="checkbox"/> Crying                 | <input type="checkbox"/> Increased smoking  | <input type="checkbox"/> Under eating               |
| <input type="checkbox"/> Decreased energy       | <input type="checkbox"/> Isolation          | <input type="checkbox"/> Vomiting                   |
| <input type="checkbox"/> Decreased interests    | <input type="checkbox"/> Loss of control    | <input type="checkbox"/> Under sleeping             |
| <input type="checkbox"/> Employment difficulty  | <input type="checkbox"/> Nightmares         | <input type="checkbox"/> Fearful                    |
| <input type="checkbox"/> Flashbacks             | <input type="checkbox"/> Overeating         | <input type="checkbox"/> Other: _____               |

**VI. ABOUT YOUR EDUCATION**

What is the highest level of education you have completed? \_\_\_\_\_

While in school, did you have a learning disability that required additional services? If so, please describe. \_\_\_\_\_  
\_\_\_\_\_

While in school, did you have behavioral problems? If so, please describe. \_\_\_\_\_  
\_\_\_\_\_

**VII. RELATIONSHIP INFORMATION (if applicable)**

If you are married, is this your first marriage? \_\_\_\_ YES \_\_\_\_ NO; If not, how many times have you been married? \_\_\_\_\_

Is this your spouse's first marriage? \_\_\_\_ YES \_\_\_\_ NO

Are there step-children involved? \_\_\_\_ YES \_\_\_\_ NO

On a scale of 1 – 10, how would you rate your relationship? \_\_\_\_\_

What difficulties are you facing in your relationship? \_\_\_\_\_  
\_\_\_\_\_

Have either you or your partner threatened to separate or divorce as a result of the current problems? \_\_\_\_ YES \_\_\_\_ NO; if yes, please explain who and what problem(s). \_\_\_\_\_  
\_\_\_\_\_

How frequently have you had sexual relations during the last month? \_\_\_\_\_

On a scale of 1 – 10, how enjoyable is your sexual relationship? \_\_\_\_\_

On a scale of 1 – 10, how satisfied are you with the frequency of your sexual relations? \_\_\_\_\_

On a scale of 1 – 10, to what degree do your family or friends support you as a couple? \_\_\_\_\_

On a scale of 1 – 10, to what degree do you and your partner share a similar worldview? \_\_\_\_\_

**VIII. ADDITIONAL INFORMATION**

What is your current job description? \_\_\_\_\_  
\_\_\_\_\_

On a scale from 1 – 10, how well do you enjoy your job and why? \_\_\_\_\_  
\_\_\_\_\_

Do you have legal problems? If so, please explain. \_\_\_\_\_  
\_\_\_\_\_

Are you court ordered to come into treatment? \_\_\_\_ YES \_\_\_\_ NO. If so, who is the referral source and what are the requirements and circumstances surrounding it? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your religious/spiritual background? \_\_\_\_\_  
\_\_\_\_\_

Please describe at least five (5) significant strengths that you hold about yourself. \_\_\_\_\_

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Please describe what you consider some of your weaknesses. \_\_\_\_\_

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**What are your goals/objectives for treatment?**

**Goal 1:** \_\_\_\_\_

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**Goal 2:** \_\_\_\_\_

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**Goal 3:** \_\_\_\_\_

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