Date:_______________

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 (if applicable): ____________________________ **Birthdate**: _________________

Marital status (please circle one):

Married **Never Married** **Separated** **Divorced** **Widowed**

List of child(ren) and ages (if applicable): ____

____

Home address:

____
Street City State Zip Code

Cell Phone Number: ___________________________ **Work/Home/Other**: _____________________

Email address: ____

Occupation (if applicable): ____

Referred by (if applicable):____

** By providing your phone number to Family & Child Development, you agree that we may send you text messages. Message and data rates may apply. Message frequency will vary. Reply STOP to opt - out of future messaging or HELP for more information. Please refer to our Privacy Policies for more information about how we manage your data*

II. PRESENTING PROBLEM(S)

Please give a description of the presenting problem or major complaint that brings you 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 services? _____ Yes _____ No
Have you previously been treated for addiction/substance abuse? _____ Yes _____ No

List of Prior Treatment Facilities:

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**

_____ **Avoiding/people/places**
_____ **Concentration problems**
_____ **Crying**
_____ **Decreased energy**
_____ **Decreased interests**
_____ **Employment difficulty**
_____ **Flashbacks**
_____ **Increased drinking**
_____ **Increased energy**
_____ **Increased smoking**
_____ **Isolation**
_____ **Loss of control**
_____ **Nightmares**
_____ **Overeating**
_____ **Taking mood altering drugs**
_____ **Temper outbursts**
_____ **Under eating**
_____ **Vomiting**
_____ **Under sleeping**
_____ **Fearful**
_____ **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**

If you do engage, what do you mostly use? Do you feel like it is interfering with your current goals?

____

____

Are you experiencing overwhelming grief/depression? _____ Yes _____ No; **for how long?** __________

Are you experiencing anxiety/panic attacks/phobias? _____ Yes _____ No; **for how long?** ___________

Have you ever felt/Do you feel you would be better off dead? _____ Yes _____ No; **If this was a past feeling, when was the last time you felt that way?** ____

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): ____________________________________

____

____

Does your family have a history of physical, emotional, verbal, or sexual abuse? ______Yes ______ No

Please list any victims you know of, 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.		
_____Alcoholism	_____ Epilepsy	_____ Kidney disease
_____ Allergies	_____ Head trauma	_____ Liver disease
_____ Anemia	_____ Hearing problems	_____ Seizures
_____ Cancer/tumors	_____ Heart disease	_____ Smoking
_____ Diabetes	_____ Hepatitis	_____ Stroke
_____ Eating problems	_____ High blood pressure	

Please check the symptoms or conditions that frequently apply to you.		
_____ Abdominal pain	_____ Fainting	_____ Sexual problems
_____ Attention problems	_____ Hurting others	_____ Risk taking
_____ Avoiding activities	_____ Impulsiveness	_____ Spending sprees
_____ Avoiding/people/places	_____ Increased drinking	_____ Taking mood altering drugs
_____ Concentration problems	_____ Increased energy	_____ Temper outbursts
_____ Crying	_____ Increased smoking	_____ Under eating
_____ Decreased energy	_____ Isolation	_____ Vomiting
_____ Decreased interests	_____ Loss of control	_____ Under sleeping
_____ Employment difficulty	_____ Nightmares	_____ Fearful
_____ Flashbacks	_____ Overeating	_____ 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 no, how many times have you been married before?** ____

Is this your spouse's first marriage? _____ Yes _____ No; **If no, how many times have they been marries before?** ____

Are there step-children involved? _____ YES _____ NO

On a scale of 1 – 10, how would you rate your relationship overall? ______________________________

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 any 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. ________________

____
____

____

Please describe what you consider some of your weaknesses. _________________________________

____
____

____

What are your goals/objectives for treatment?

Goal 1: ____
____

Goal 2: ____
____

Goal 3: ____
____