J Hunter Counseling

Intake Form

Name: _____ **Birth Date**: _____

Address: _____

Chief Concern- Please describe the main difficulty that has brought you to see me:

_____

Your medical care (From whom or where do you get your medical care?)

Clinic name: _____

Phone: _____

Primary Care Provider: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? _____Yes _____ No

Your current employer

Employer: _____

Work phone: _____

Address: _____

Occupation: _____

Length of time with this employer: _____

Present relationships: _____

How do you get along with your spouse or partner?

_____

How do you get along with your children?

_____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

_____Yes _____ No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

When: _____

From Whom: _____

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For What: _____

Results:

Have you ever taken medications for psychiatric or emotional problems? _____Yes _____ No

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

Have you experienced the following symptoms: Circle all that apply

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when? _____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

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Family:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Friendships:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Physical health:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Mood:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect 6 – N/A

Substance Use

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Do you currently consume alcohol? _____Yes _____ No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? _____Yes _____ No

Have family members or friends expressed concern about your drinking? _____Yes _____ No

Do you currently use non-prescribed drugs or street drugs? _____Yes _____ No

Do you have a history of problematic use of prescription or non-prescription drugs? ____Yes ___ No

Do you have a family history of alcohol or drug problems? _____Yes _____ No

If yes, please describe:

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms?

_____
_____
_____