paulelmore
6901 SE Lake Rd., #4
Milwaukie, OR 97267
(503) 863-4074

Date _____

Intake Form

Contact Information

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Messages Okay?: O Yes O No

Email: _____

Emergency Contact

Name: _____

Relationship: _____ Phone: _____

Who Referred You?

Organization: _____

Individual: _____

Occupation

Employer: _____ Title: _____ How Long: _____

Counseling Services

Counseling Services

Which type of counseling services are you seeking?

O Individual O Couples O Family O Assessment O Consultation

Please describe the issues for which you're seeking counseling. _____

Issues

Check all that apply

O Suicidal Thoughts
O Mood Swings
O Lack of Energy
O Excess Energy
O Racing Thoughts
O Slowed Thinking
O Guilty Feelings
O Pornography
O Depression
O Anxiety
O Panic Attacks
O Confusion
O Alcohol/Drugs
O Sexual Acting Out
O Relationship Problems
O Family Issues
O Marriage Problems
O School Problems
O Unusual Experiences
O Trauma/PTSD
O Emotional Extremes

Suicide Evaluation

Are you feeling suicidal currently: O Yes O No Intensity: (1-10 scale) _____

Time Frame: _____ Method: _____

Past suicidal behaviors: O Contemplated O Attempted O Multiple Attempts

Past Interventions: _____

Physical Health

Rate Your Overall Physical Health: O Good O Fair O Poor

Current health concerns: _____

Are you in any physical pain? Describe: _____

Current Alcohol Use: O None O Occasionally O Frequent O Problematic

Current Drug Use: O None O Occasionally O Frequent O Problematic

Medications

Medication	Dosage/Amt	Prescribed	Physician
		O Yes O No	
		O Yes O No	
		O Yes O No	
		O Yes O No	

Recent Changes

Any recent changes in any of the following:

O Sleeping Patterns
O Eating Patterns
O Behavior
O Energy
O Physical Activity Level
O General Disposition
O Weight
O Anxiety/Depression
O Other: _____

History

Counseling History

Previous Counseling Experiences: O None O Positive O Negative O Uncertain

Most Recent Counselor

Name: _____ Dates: _____

Agency: _____ Phone: _____

Phone: _____

Diagnosis/Evaluation: _____

Why did you stop? _____

Past Counseling

Previous Diagnosis/Evaluations: _____

Hospitalizations

When: _____ Facility: _____

Reason: _____

Family History

Family Mental Health Problems: Please check all that apply.

- O Depression
- O Anxiety
- O Alcohol Abuse
- O Drug Abuse
- O Sexual Abuse
- O Psychiatric Disorders
- O Schizophrenia
- O OCD
- O PTSD
- O Suicide
- O Anxiety/Panic Attacks
- O Eating Disorders

Personal History

Have you experienced any of the following situations? Please check all that apply.

- O Neglect
- O Emotional Abuse
- O Physical Abuse
- O Sexual Abuse
- O Teenage Pregnancy
- O Violence In The Home
- O Parental Illness
- O Frequent Relocation
- O Homelessness
- O Financial Crisis
- O Divorce
- O Suicide
- O Loss Of A Loved One
- O Natural Disaster
- O Victim Of A Crime

Relationship Information

Current Relationships

Marital Status:

- O Single
- O Married—How long _____
- O Separated—How long _____
- O Divorced—How long _____
- O Partner—How long _____
- O Number of Marriages _____
- O Divorce in Progress—How long ____
- O Widowed—How long _____

Problems in Current Relationship:

- O Money
- O Physical Abuse
- O Addiction/Alcohol/Drugs
- O Sexual Issue
- O Child Rearing/Parenting
- O Religious/Spiritual
- O Mental Illness
- O Other _____

Children (& ages):

#1: _____ #4: _____

#2: _____ #5: _____

#3: _____ #6: _____

Family of Origin Information

Parents/ Guardians:

Father: _____ Step-Father: _____

Mother: _____ Step-Mother: _____

Additional: _____

- O Parents Legally Married (# Years _____)
- O Parents Separated
- O Parents Divorced—What age were you?_____
- O Parents Never Married
- O Mother Remarried (# of times _____)
- O Father Remarried (# of times _____)
- O Mother Affairs (# of times _____)
- O Father Affairs (# of times _____)

Siblings/ Birth Order

In birth order, list all the children in your family. **Be sure to include yourself.**

#1: _____ #4: _____

#2: _____ #5: _____

#3: _____ #6: _____

Social Support System

What is your social support system? Check all that apply.

- O Adequate Social Support
- O Difficulty Establishing Friendships
- O Difficulty Maintaining Friendships
- O Difficulty Establishing Romantic Relationships
- O Difficulty Maintaining Romantic Relationships
- O Conflict With Peers

You feel lonely… O Rarely O Sometimes O Often O Most of the time

Have you informed your **immediate family** that you are seeking counseling? O Yes O No

Have you informed your **friends** that you are seeking counseling? O Yes O No

Personal Information

Interests & Hobbies (Optional)

Check all that apply:

- O Art
- O Music
- O Crafts
- O Sports
- O Books/Film
- O Physical Fitness
- O Outdoors
- O Diet/Health

Current Memberships (Clubs, Organizations): _____

Do you participate in any cultural activities related to your ethnic background? O Yes O No

Sexuality (Optional)

Are you currently sexually active? O Yes O No

Have you been sexually active in the past? O Yes O No

What is your sexual preference? O Male O Female O Both O Uncertain

Are there any sexual issues you'd like to discuss in the counseling process? O Yes O No

Spirituality Practices (Optional)

Was faith, spirituality, or religion part of your childhood? O Yes O No

What faith system were you raised in? _____

What faith system do you ascribe to now? _____

Church Attending: _____ How Long: _____

Do you want issues of faith to be integrated into your counseling experience? O Yes O No

Education (Optional)

- O Graduated High School
- O High School Diploma (GED)
- O Did Not Graduate High School—Last Grade Completed _____
- O College Graduate—Degree in _____ O Currently enrolled
- O Graduate Degree—Degree in _____ O Currently enrolled
- O Vocational School—Type _____ O Currently enrolled
- O Other _____

Special Circumstances (learning disabilities, gifted programs, special education, etc…)

_____

Military Experience (Optional)

Branch: _____ Type of Discharge: _____

Enlistment Date: _____ Rank at Discharge: _____

Discharge Date: _____ Combat Experience (where): _____