Counseling Intake Form

CONFIDENTIAL

"Life History" Questionnaire

Please fill out whatever is applicable to you.
If you need more space for any answer, please us the back of the sheet.

General Information

Today's Date: _____

Name: _____ Male/Female

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Referred by: _____

Phone: (home) _____ Work: _____

Cell: _____ Email: _____

Martial Status (circle one)

Single Engaged Married Separated Divorced Widowed

Are you a student? Yes ____ No ____ Where? _____

Studying what? _____

Employed? Yes ____ No ____ Full Time/Part Time ____

Employment Date _____

Employer _____

Address _____

Occupation _____

Presenting Problem

Please state in your own words the main reason for seeing counseling.

On the Scale below, please estimate the severity of your problems:

Mildly Upsetting ____ Moderately Upsetting ____ Very Upsetting ____

Extremely Upsetting ____ Totally Upsetting ____

When did your problems begin? Please give dates.

Please describe significant events occurring at the time or since then which may relate to the development or maintenance of your problem.

So far, what solutions to your problems have been helpful?

Have you been in counseling before or received any professional assistance for these or other problems? If so, please give names, professional titles, dates of treatment and results.

Have you ever been hospitalized for psychological problems? Yes ____ No ____ If yes, when and where?

PERSONAL AND SOCIAL HISTORY

Siblings: Please list all of your siblings by sex, name, age and if they are still living. For those decreased, please give date and cause of death.

Male/ Female	Name / Relationship	Age	Living / Deceased	If deceased, date of death & cause

If your father is living, what is his age? ____ His occupation? _____

State of his health? _____

If your father is deceased, what was his age at the time of death? _____

How old were you at the time? _____ Her occupation? _____

If your mother is living, what is her age? ____ Her occupation? _____

If your mother is deceased, what was her age at the time of death? _____

How old were you at the time? ____ Cause of death? _____

If Applicable, please provide the following information

Name of your Spouse (current) _____

Spouse's Age ____ Spouse's Occupation _____

When married? _____

How long did you know one another before your engagement? _____

Martial Status: Still Married ____ Separated ____ Divorced ____ Deceased ____

When? _____

How Many times married? _____

Children: Please list children by sex, name, and age.

Male/ Female	Name	Age	Living / Deceased	If deceased, date of death & cause

Name of your Spouse (former) _____

Spouse's Age ____ Spouse's occupation _____

When married? _____

How long did you know one another before your engagement? _____

Marital Status: Divorced ____ Deceased ____ When? _____

CHILDREN: Please list children by sex, name, and age.

Male/ Female	Name	Age	Living / Deceased	If deceased, date of death & cause

FRIENDS

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? Yes ____ No ____

RELIGION

As a Child? _____

As an Adult? _____

EDUCATION

Last grade completed? _____ Degree? _____

How would you describe your academic performance:

Excellent ____ Above Average ____ Average ____ Low Average ____ Low ____

What were scholastic strengths and weakness?

Did you date much in high school? Yes ____ No ____

Did you date much in college? Yes ____ No ____

Circle any of the following that applied during your childhood/adolescence:

Happy Childhood	School Problems	Medical Problems
Unhappy Childhood	Family Problems	Alcohol Abuse
Emotional / Behavioral Problems	Strong Religious Convictions	Drug Abuse
Legal Problems	Other	

Do you have a family physician? If YES, please provide the following:

Physician's Name _____

Address _____

Phone Number _____

Do you own a gun? Yes ____ No ____

Have you ever attempted suicide? Yes ____ No _____

Does any member of your family suffer from, Alcoholism, Epilepsy, Depression, Mental Disorders? If yes, please describe:

Has any relative attempted or committed suicide? Yes ____ No ____

Has any relative had serious problems with the law? Yes ____ No ____

PHYSICAL SENSATIONS
CIRCLE any of the following that often apply to you:

Headaches	Stomach trouble	Skin Problems
Dizziness	Tics	Dry Mouth
Palpitations	Fatigue	Burning or itchy skin
Muscle Spasms	Twitches	Chest pains
Tension	Back pain	Rapid heart beat
Sexual disturbance	Fainting spells	Blackouts
Bowel disturbances	Hearing things	Excessive sweating
Tingling	Watery eyes	Visual Disturbance
Numbness	Flushes	Hearing problems

Female clients please complete this section.

MENSTRUAL HISTORY

How old were you when you got your first period? _____

Were you informed or did it come as a shock? _____

Is your period regular? Yes ____ No ____

Do your periods effect your mood? Yes ____ No ____

Duration? _____ Date of last period? _____

Any relevant information about abortions or miscarriages? If yes, please describe:

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Yes ___ No ___
If YES describe:

Are you currently taking medications? Yes ____ No ____
If yes, please list any medications you are currently taking, or have taken during the past six months include aspirin, birth control, prescription or over the counter medicines.

CIRCLE any of the following that apply to you or members of your family

Thyroid disease	Kidney disease	neurological diseases	asthma
Diabetes	cancer	epilepsy	gastrointestinal disease
Glaucoma	Prostate problems	Other _____	

Are you currently (or have ever been) in an abusive relationship? Yes ____ No ____

Have you had accidents or injuries not previously describe? Yes ____ No ____
If yes, please provide details and dates:

Have you ever had any head injuries or loss of consciousness? Yes ____ No ____
If yes, please give details and dates:

Have you had surgery? Yes ____ No ____
If yes, please give details and dates:

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens, LSD				
Diarrhea				
Constipation				
Allergies				
High Blood Pressure				
Heart Problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early Morning Awakening				
Fitful Sleep				
Overeat				
Poor Appetite				
Eat “Junk Foods”				