parkdale therapy group

MHG INTAKE FORM

These forms will give you an opportunity to describe some of your experiences, history and the struggles that are bringing you to therapy.

CLIENT INFORMATION

Name:____

Parent (if client is child):___________________________________

Date of Birth:______________________ Age: ________ Male Female Other

Address:____

City, State, Zip:____

Occupation:______________________Employer: ______________________

School (if student):____

Phone (h): ______________________ Messages ok at home? Yes No

Phone (cell): ______________________ Messages ok on cell? Yes No

Phone (w):______________________ Messages ok at work? Yes No

Email: ______________________ Emails ok? Yes No
(Note: I cannot guarantee the confidentiality of email.)

Religious Affiliation: ____

Ethnic/Cultural Heritage: ____

MARITAL STATUS Length of current marriage/relationship: ______________________

Single Married (legally) Divorced Total # of marriages: ______________________

Cohabitating Divorce in process Separated Widowed Other:______________________

Assessment of current relationship (if applicable): Good Fair Poor

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FAMILY INFORMATION

Relationship Name Age Sex Type(bio, step, etc.)

Mother____

Father____

Spouse/SO________________________ ______ ______ _________________

Children/ ________________________ ______ ______ _________________
Siblings

________________________ ______ ______ _________________

________________________ ______ ______ _________________

EDUCATION

Fill in all that apply: Years of education:______________Currently enrolled: Yes No

High School/GED College Vocational Graduate School

Other training:____

Special circumstances:____

MILITARY

Military experience? Yes No Combat experience? Yes No

Where:________________Branch:__________________Length of service:________________

Type of discharge:______________________ Rank at discharge:___________________________

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What activities do you enjoy and feel you are successful when you try?

What personal qualities would others say you have?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No If so, where: ______________________________

Approximate Dates of Counseling: ____

For what reason? ____

Do you have a previous mental health diagnosis? ____

What did you find **most helpful** in therapy?

What did you find **least helpful** in therapy?

Please describe your past and current use of drugs and alcohol and any time spent in treatment:

Have you used psychiatric services? Yes No Was it helpful? Yes No

Have you taken medication for a mental health concern? Yes No

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Name of medication	Dates Taken	Helpful?(Y/N)

Do you have other medical concerns or previous hospitalizations? Please describe.

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your child/adolescent to have counseling?

What would you like to see happen as a result of counseling?

What is most concerning right now?

FAMILY HISTORY

Who lived in your home when you were a child?

What is your birth order?

What word would you use to describe your family of origin?

Are you aware of any birth trauma your mother had during her pregnancy with you, or from age 0- 3?

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Did/do you have any significant issues with someone in your family? Please describe.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

FAMILY CONCERNS

Please check any family concerns that you are having.

Fighting
Feeling Distant
Loss of fun
Lack of honesty
Physical fights
Education problems
Financial problems
Death of family member
Abuse/Neglect
Inadequate housing or feeling unsafe
Job Chance or dissatisfaction

Disagreeing about Relatives
Disagreeing about Friends
Alcohol Use
Drug Use
Infidelity (Couple)
Divorce/Separation
Remarriage (self or parent)
Birth of Sibling
Birth of Child
In adequate health insurance or access to
Other

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Symptom	None	Mild	Moderate	Severe		Symptom	None	Mild	Moderate	Severe
Sadness/Depression						Increased or decreased appetite				
Crying						Unplanned weight gain				
Sleep disturbances						Unplanned weight loss				
Dissociation						Paranoid thoughts				
Hyperactivity						Poor concentration/indecisive				
Binging/Purging						Low energy				
Decreased sex drive						Excessive worrying				
Unresolved guilt						Low self-worth				
Irritability						Anger management problems				
Nausea/Acid indigestion						Spiritual concerns				
Social anxiety						Hallucinations				
Self-mutilation/cutting						Racing thoughts				
Impulsivity						Restlessness				
Nightmares						Drug Use				
Hopelessness						Alcohol Use				
Elevated mood						Decreased creativity/productivity				
Mood swings						Easily distracted				
Disorganized						Memories of trauma/flashbacks				
Anorexia						Work issues				
Social isolation						Problems at home				
Phobia(s)						Panic attacks				
Obsessive thoughts						Feel panicky/anxious				
Grief						Suicidal thoughts				
Headaches						Has attempted suicide in the past				
Loneliness						Other				

ADDITIONAL INFORMATION

Is there anything else you would like to share:

____________________________________ ____________________

Client Signature | Date