ptg parkdale therapy group

Megan O'Brien 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 ○

ptg parkdale therapy group

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: _____

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

What personal qualities would others say you have and what characteristics do you like most about yourself?

What is your spirituality or source of peace, love or joy?

What spiritual resources do you have, if any? By what name do you call your spiritual supports?

Who loves you and supports you in your life now?

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?

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

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

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

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

Do you have any serious or chronic medical conditions? If yes, dates & details:

Do you have any chronic pain, recurring body aches, or soreness? Where is your body distress?

Have you had any serious accidents/head injuries/seizure activity? If yes, dates & details:

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?

Who loved you unconditionally from 0 to 18 years of age? Who gave you positive reinforcement?

Who loves you and supports you in your life now?

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?

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	Disagreeing about Relatives
Feeling Distant	Disagreeing about Friends
Loss of fun	Alcohol Use
Lack of honesty	Drug Use
Physical fights	Infidelity (Couple)
Education problems	Divorce/Separation
Financial problems	Remarriage (self or parent)
Death of family member	Birth of Sibling
Abuse/Neglect	Birth of Child
Inadequate housing or feeling unsafe	In adequate health insurance or access to
Job Chance or dissatisfaction	Other

ptg parkdale therapy group

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 _____