hope PERFORMANCE SYSTEMS

Counseling Intake Information

Client Name: _____ Age:_____

Briefly describe the reason you decided to seek our services:_____
_____
_____
_____

Please check any of the following that you are currently struggling with:

Relationship Difficulties
Marital/Partner
Communication
Multi-family
In-laws
Parents
Brother/Sister
Sexual
Separation
Divorce
Dating
Premarital

Situational Difficulties
Death of a Loved One
Violence (real/threatened)
Physical Abuse (past/ current)
Sexual Abuse (adult/child)
Legal
Major Loss/Changes
Stress
Past
Friends
Religion

Decision MakingPhysical/ Health Difficulties
Headaches
Stomach
Physical Disability
Bed-wetting
Eating Disorder
Sleep
Chronic Pain

Emotional Difficulties
Depression
Suicidal Thoughts
Suicidal Actions
Sadness
Unhappiness
Nervousness/Panic Attacks
Anger/Temper

Work/School Difficulties
Unemployed
Job/School
Education
Finances
Career Choices
Learning Disability

Children
Misbehaving
Child having Problems
Parenting Issues
Parent-Child Conflict (self)
Parent-Child Conflict (partner)

Personality Concerns
Fears
Loneliness
Sexuality Issues
Confusion
Relaxation
My Thoughts
Alcohol/Drug Use or Abuse
Low Self-esteem
Shyness
Guilt
Assertiveness
Self-control
Compulsive Gambling

Counseling Initial IntakePlease list three items that are causing you the MOST difficulty:
1)

2)

3)

Have you had counseling in the past? Yes/No When? _____

Where? _____

For how long? _____

For what reason?_____

Problems with Coping
Please check all that apply to you.

Moody or crying more than usual
Problem remembering things
Panic attacks
Feeling guilty, worthless, hopeless
Hyper/Too much energy
Disturbing thoughts you can't stop
Difficulties concentrating
Withdrawing from others
People picking on you
Fatigue/Low energy
Loss of interest in things
Extreme worry of fears

Repeated actions you can't stop
Can't stop counting/checking things
Can't stop washing hands/body

Hallucinations
I hear things that are not real
I smell things that are not real
I see things that are not real
I feel things that are not real

Sleep Difficulties
Waking up in the middle of the night
Waking up too early
Nightmares
Can't fall asleep
Sleeping too much

Appetite Difficulties
Gaining weight
Not hungry/eating
Feeling sick to your stomach
Losing weight
Throwing up after eating

Self-harm
I cut myself
I hit myself
I burn myself
Other: _____

List any previous Suicide Attempts (if none, write 'none')
When?_____ Method?_____
When?_____ Method?_____
When?_____ Method?_____

Have you recently been thinking about hurting or killing yourself? Yes/No
Have you recently been thinking about hurting or killing someone else?Yes/No

List any health problems you are currently receiving treatment for: _____
_____
_____

Are you currently taking any medications? Yes/No

Medication Name	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If more please list on a separate piece of paper

Who is your family Doctor?_____

When was your last physical exam?_____

Please describe your current use of alcohol/drugs, include type, amount and frequency (if none, write 'none'). _____
_____
_____

Does your family have a mental health or substance abuse history? Yes/No
If yes, please list._____
_____
_____

Are you currently involved in any legal proceedings? Yes/No
If yes, please list._____
_____
_____

What is your religious preference? _____

Please list any family, friends, support groups or others that are helpful to you:
_____
_____

Your goals in CounselingGoals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to attain, be as specific as possible.
1)

2)

3)

How many sessions do you THINK you will need to attain these goals? (your best guess) Please check.

1-3 sessions
10-12 sessions
4-6 sessions
13-15 sessions
Other: