Comprehensive Intake Worksheet

Date: _____/_____/_____

Name: _____
Last First MI

Local Address: _____
Street City Zip Code

Permanent Address: _____
Street City Zip Code

Phone # you can be reached at (cell)_____(other)_____

Email: _____

Emergency contact info: _____
Name #

Identifying Information

Date of Birth: _____ / _____ /_____ Age: _____ Ethnicity: _____

Relationship Status: _____ Living Situation: _____

Academic Data (if applicable):

College Student? Yes / No Status: PT/FT Major: _____

Highest Degree Completed _____ Military Service? Yes / No

Have you ever had counseling before: If yes, please specify when, where and for what issues: _____

_____

_____

Presenting Problem:

What has led you to seek counseling? _____

_____

_____

What is the history of the issue, including symptoms and duration? _____

_____

_____

Background Information:

Trauma History:

- Current thoughts of suicide Yes / No
- Previous attempts at suicide Yes / No
- Prior psychiatric hospitalizations Yes / No
- Current self-injurious behavior (e.g. cutting self) Yes / No
- Current thoughts of harming someone else Yes / No
- Current visual or auditory hallucinations: Yes / No

Below is a list of issues that cause concern. Please indicate those that currently apply to you.

Interpersonal Concerns:

_____ Relationships with friends/roommate(s)

_____ Relationship with parents/family

_____ Relationship with significant other

_____ Adjusting to transition (please specify)_____

_____ Social anxiety concerns

_____ Difficulty making friends

_____ Difficulty being assertive

Depressive symptoms:

_____ Irritability/anger issues

_____ Over eating/ undereating

_____ Feeling hopeless/worthless/guilty

_____ Decreased interest in activities

_____ Extreme mood swings

_____ Problems sleeping

_____ Sad mood

_____ Crying for “no reason"

_____ Lack of energy/motivation

Anxiety symptoms:

_____ Fearful for no apparent reason

_____ Heart palpitations

_____ Dizziness

_____ Fear of losing control or "going crazy"

_____ Excessive worry

_____ Shakiness/hot flashes

_____ Obsessive thoughts/ images/ worries

_____ Repetitive behaviors or mental acts

Trauma:

_____ History of sexual abuse

_____ History of physical abuse

_____ Date rape·

_____ Victim of violence

_____ History of emotional/verbal abuse

_____ History of violence in relationships

_____ Unwanted sexual contact

Other : _____

Eating Concerns:

_____ Binge eating

_____ Restricting food intake

_____ Pre-occupation with food/dieting

_____ Purging after eating

_____ Body image

_____ Excessive exercising (more than 4 times a week)

Legal Concerns:

_____ Court or other legal mandate

Miscellaneous Concerns:

_____ Ethnic/racial

_____ Financial

_____ Sexually Transmitted Infection

_____ Pregnancy

_____ Sexual identity/ orientation/ gender

_____ Mental illness in family

_____ Grief/ loss

Medical History:

Are you taking any prescribed medications? Yes / No

Are you allergic to any medications? Yes / No

If yes, please specify:_____

Do you have any medical problems or concerns? Yes / No

If yes, please specify:_____

Alcohol/Drug:

_____ Concerned about own use

_____ Concerned about another's use

_____ Alcoholism in family

Alcohol/Drug Assessment:

Drug	Age of 1st Use	How often are you currently using?				Date of last use
Alcohol	_____	Never	Daily	Weekly	Monthly	
Marijuana	_____	Never	Daily	Weekly	Monthly	_____
Cocaine	_____	Never	Daily	Weekly	Monthly	_____
PCP	_____	Never	Daily	Weekly	Monthly	_____
Ecstasy	_____	Never	Daily	Weekly	Monthly	_____
Other:			Daily	Weekly	Monthly	_____

Family History:

Family Members Name/Relationship	Age	Occupation	Medical/Mental Health Substance Abuse History

Please take a moment to tell us any other concerns you may have or issues you would like to discuss with your counselor. Thank you!