Healing Relationships
Affecting
All Generations

Family Integration Counseling Service, Inc.

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www.familyintegrationcounseling.com

Therapy Intake

Client Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Email: _____

D.O.B. _____ Ethnicity: _____ County Of Residence: _____

Where can confidential messages be left? _____ Occupation: _____

Other Contact (Work, Pager, etc.) _____

Vehicle Information (Year, Make, Model, Color): _____

License Plate Number: _____

Spouse/Partner Name: _____ Cell Phone: _____

D.O.B. _____ Ethnicity: _____ Email: _____

Where can messages be left? _____ Occupation: _____

Other Contact (Work, Pager, etc.) _____

Insurance Company: _____ _____

Subscriber ID: _____ Group #: _____

Registered Address: _____ Primary Subscriber

_____ Subscriber Name: _____

Authorization Number: _____ Subscriber Date of Birth: _____

Emergency Contact

Who can be contacted in the case of a medical emergency?

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Church: _____

_____

Pastor: _____

Phone: _____

Attendance: ❒ Weekly ❒ Monthly

❒ Varies ❒ Other: _____

Referral Source: _____

Goals

Whose idea was it for you to come today?

What do you want to work on while in counseling?

What seems to help with this problem?

What signs have you had recently that tell you things are getting better?

How will you know when it is time to stop counseling?

What are the goals of others (parents, social services, etc)?

Personal Characteristics:

Describe yourself:

What do I need to know about your to work with you the best?

Spiritual History

What is your spiritual background?

What religion and denomination do you most closely associate with?

Do you currently belong to a spiritual community? If so where?

Would you like to incorporate spiritual concerns into counseling? If so, please explain:

Is there anyone you would like to incorporate into your treatment process (pastor, mentor, etc)?

What is your level of commitment to a spiritual life and process?

Family History

Genogram (to be completed in therapy)

Information on generational patterns (Do you have a history of these in your family):

a. Mental Illness:

b. Substance Abuse:

c. Physical Illnesses:

d. Sexual Abuse:

Family and Social Patterns

Marital Status (circle) Single Married Cohabitating Divorced Re-Married

Other (dating relationships): _____

Name of Spouse or Partner: _____

Names of Children Ages

_____
_____
_____
_____
_____
_____

Information Familial Relationships:

a. Please describe your relationship with your Father:

b Please describe your relationship with your Mother:

c. Please describe your relationship with your siblings:

Marriage:

a. Describe your parent's marriage:

b. Describe your own marriage or dating relationships:

c. Have you had a history of affairs (including premarital cheating) in your relationships?

Attachment Disruption

Did you have any breaks in major relationships as a child (parent died, divorce, hospitalizations)?

Who were you closest to growing up?

Educational Status:

1. What is your highest completed grade?

2. Describe your academic performance in school:

3. Describe your behavior at school:

4. Do you have any learning disabilities?

Occupational Status:

1. What jobs/careers have you had? Include years in each career.

2. What were your reasons for leaving your last job?

3. Please describe your performance on the job in your own opinion.

4. What are your likes/dislikes about your occupation?

Legal Status:

1. Describe your arrest record:

2. Have you ever been incarceration in a State or County detention facility (Where & Duration)?

3. What is your current legal standing (including criminal and civil actions)?

4. Is therapy mandated by the court? If so, please describe treatment that is required by the court:

Traumatic Experiences:

Have you ever experienced any of the traumatic situations below?

1. Sexual:

2. Physical:

3. Emotional (derogatory comments, insults, power abuses):

4. Domestic Violence (directly or witnessed):

5. Spiritual (threats about God, punishment, inappropriate guilt):

Treatment History

What is your most significant problem you want to work on in therapy?

Frequency / How often does it occur?

Duration / How long does it last for?

Intensity / How bad is this problem?

Previous coping / What has helped your problem in the past (*include parents interventions)*?

1. Previous Mental Health Treatment:

2. Medication (omit short term pain meds, antibiotics, etc.):

Type	Dose	Start Date	End Date	Effects

3. Psychiatric (medical) Status: (USE THE BACK OF THIS PAGE FOR ADDITIONAL INFORMATION)

a. Describe previous medical treatment for emotional/behavioral problems:

b. What was helpful or not? Describe any positive effects and side-effects:

c. With whom & for how long (please complete *Release of Information* to coordinate care):

d. What are your thoughts on current medical treatment?

Medical Status:

1. Personal Physician: _____ Date of last physical: _____

Business Name: _____ Health concerns raised: _____

Address: _____ _____

_____ _____

Phone: _____ _____

Fax: _____ _____

2. Do you have any chronic illnesses?

3. How is your eye sight (glasses)?

4. How is your hearing (hearing aid)?

5. Have you suffered a head injury?

Have you ever had concussions or suspected a concussion?

6. Have you ever had any significantly high fevers (over 103^{o})?

7. Have you ever had difficulty mobility (paralysis, bed ridden, long term hospitalization)?

9. Have you ever been hospitalized?

10. Do you have any physical disabilities?

11. Do you or any family members have a seizure disorders (describe)?

Childhood Behavior Problems

Please report problems you had before the age of 12. Mark with either a "C" or "Hx".

Behavioral Issues:
"C" Current Behavior (started before 12 years old and still is a problem)
"Hx" Historical Behaviors (started before 12 years old but not a problem at this time)

Last known date of incident is noted

____Criminal Charges _____
____Anxious_____
____Argument _____
____Assault _____
____Bizarre Behaviors _____
____Bedwetting _____
____Defiant _____
____Delinquent_____
____Demanding _____
____Depressed _____
____Destruction of Property_____
____Disorientation / Confusion _____
____Eating Disorder _____
____Bowel Problems _____
____Urine Problems _____
____Failure to Thrive _____
____Fantasy _____
____Fire Setting _____
____Grandiose Thinking _____
____Gang Association _____
____Harmful to Animals _____
____Homicidal _____
____Hygiene Problems_____
____Hyperactive_____
____Highly-dependent _____
____Impulsive _____
____Inactive/Low Motivation _____
____Inappropriate Emotional Expression
____Inattentive _____

_____ Isolated / Withdrawn _____
_____ Low Tolerance _____
_____ Low Self-Esteem _____
_____ Lying _____
_____ Manipulative _____
_____ Mood Disruption _____
_____ Obsessive Compulsive _____
_____ Occult / Satanism _____
_____ Paranoid Thinking _____
_____ Phobic _____
_____ Physical Medical Problems _____
_____ Poor Verbal Skills _____
_____ Physically Aggressive _____
_____ Pregnant _____
_____ Repetitive Movements _____
_____ Running Away _____
_____ Self-Endangering _____
_____ Self-Mutilation _____
_____ Sexually Aggressive _____
_____ Social Immaturity _____
_____ Sexual Inappropriate Acts _____
_____ Sleep Disturbance _____
_____ Stealing _____
_____ Substance Abuse _____
_____ Suicidal Ideation/Gesture _____
_____ Swearing _____
_____ Temper Tantrums _____
_____ Verbal Aggression / Hostile _____
_____ Violation Curfew _____

Self Report Behavior Problems

Client Name: _____

Instructions: Below is a list of problems people sometimes face. Carefully read each problem. Them for each problem which is currently causing you problems, circle the appropriate response to the right indicating the current amount of distress it causes you. Then circle the appropriate response which indicates how long you have had this problem.

	How much does it bother you				How long has it been a problem				
Symptoms	None	a bit	Some	a Lot	1 week	1-6 month	6-12 months	1-3 years	3+ years
Anxiety, worry, tension, panic									
Stress Management									
Concentration, distraction, focus									
Death, Grief and Loss									
Depression, sadness									
Guilt, hopelessness									
Social Isolation									
Perfectionism									
Physical Health, pain									
Victim of Abuse, painful memories									
Self-esteem, self-confidence									
Sleep Problems									
Test Anxiety									
Break-up, Loss of Relationship									
Dating Concerns									
Emancipation, Leaving Home									
Loneliness									
Making Friends									
Relationship with Family									
Relationship with friends									
Relationship with romantic partner									
Sexual Concerns									
Shyness, Public Speaking									
Academic Problems									
Career Problems, College Major									
Learning Problems									
Procrastination, Motivation									
Study Skills, Time Management									
Life Transitions									
Mood Swings									
Hallucination									
Alcohol & Drug Problems									
Gambling, Internet, Spending Prob									
Violating Rules									
Over-eating, Binge/Purge									
Under-eating, Anorexia									
Anger, Irritability, Aggression									
Suicidal Thoughts, Feelings									
Sexual Assault/Rape/unwanted sex									
Religious/Spiritual Concerns									
Finances									
Weight Problems									