

C² Counseling Intake

Date: _____

Client's Name: _____

DOB: _____ Age: _____ Gender: _____

Name of parent/guardian (if under 18 years) _____

DOB: _____ Age: _____ Gender: _____

Reason for Counseling (Chief Concern): _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes

If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes No

Please list: _____

Have you been prescribed psychiatric medication? Yes No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

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3. How many times per week do you generally exercise? _____

What type of exercise do you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes No

If yes, please describe _____

8. Do you drink alcohol more than once a week? Yes No

9. How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

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FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle and List Family Member

Alcohol/Substance Abuse	yes / no _____
Anxiety	yes / no _____
Depression	yes / no _____
Domestic Violence	yes / no _____
Eating Disorders	yes / no _____
Obesity	yes / no _____
Obsessive Compulsive Behavior	yes / no _____
Schizophrenia	yes / no _____
Suicide Attempts	yes / no _____

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weakness? _____

5. What would you like to accomplish out of your time in therapy? _____
