C^2 Counseling
Intake Assessment

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? _____

_____