SPECTRUM COUNSELING

INTAKE FORM

Name_____Date_____
(Last) (First) (M. I.)
Address_____
(Number & Street) (City) (State) (Zip)
Primary Phone Number _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
Please note: email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Referred by (if any): _____Relationship_____

RELATIONSHIP INFORMATION

Marital Status: □ Married □ Partnered □ Never Married □ Separated □ Divorced □ Widowed

If married, what is your spouse/partner's name?_____ How long together?_____

If not married or partnered, are you currently in a romantic relationship? □ Yes □ No
If yes, for how long? _____

Please list any children, name and age _____ ____, _____ ____, _____ ___,
_____ ___, _____ ___, _____ ___, _____ ___, _____ ___
Please list any other persons living in your household and your relationship to them. _____
_____

PREVIOUS MENTAL HEALTH SERVICES

Have you received counseling/therapy in the past? □ Yes □ No

Name of practitioner	Date of services	Diagnosis	Reason for termination

Are you currently taking any psychiatric prescription medication? □ Yes □ No Use back if necessary

Current medication	Dosage	For how long?	Purpose	Physicians Name

Have you ever been hospitalized for mental concerns? □ Yes □ No If yes, when where, and for what reason? _____

GENERAL HEALTH INFORMATION

1. How would you rate your current physical health?
□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any 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.
_____

3. How many times per week do you generally exercise? _____ What types 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, where is the pain and when did you begin experiencing this? _____
_____
8. Have you ever served in the military? □ Yes □ No If so, which branch? _____How long?_____

9. Do you drink alcohol? □ Yes □ No If yes, how much & how often?_____ _____
Has anyone ever told you they were concerned about your frequent use of alcohol? □ Yes □ No
_____
10. How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

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

12. Have you ever, or are you currently engaging in self-harm? □ Yes □ No Currently ____ Past_____

13. Have you ever, or are you currently contemplating suicide? □ Yes □ No Currently ____ Past____
_

MENTAL HEALTH HISTORY

	Please circle	Please check/Add Comments Self	List Family Member(s)
Adoption History	Yes/No	_____	_____
Alcohol/Substance Abuse	Yes/No	_____	_____
Autism/Asperger's	Yes/No	_____	_____
Learning Disability	Yes/No	_____	_____
Extreme Depressed Mood	Yes/No	_____	_____
Wild Mood Swings	Yes/No	_____	_____
Rapid Speech	Yes/No	_____	_____
Panic Attacks	Yes/No	_____	_____
Phobias	Yes/No	_____	_____
Sleep Disturbances	Yes/No	_____	_____
Hallucinations	Yes/No	_____	_____
Unexplained Lapses of Time	Yes/No	_____	_____
Unexplained Memory Losses	Yes/No	_____	_____
Frequent Body Complaints	Yes/No	_____	_____
Eating Disorder	Yes/No	_____	_____
Body Image Problems	Yes/No	_____	_____
Miscarriage	Yes/No	_____	_____
Abortion	Yes/No	_____	_____
Repetitive thoughts/obsessions	Yes/No	_____	_____
Homicidal Thoughts	Yes/No	_____	_____
Suicide Attempt	Yes/No	_____	_____
Repetitive Behaviors (frequent checking, hand washing, etc.)	Yes/No	_____	_____

TRAUMA HISTORY

Physical abuse	Yes/No	_____	_____
Emotional Abuse	Yes/No	_____	_____
Sexual Abuse	Yes/No	_____	_____
Verbal abuse	Yes/No	_____	_____
Natural disaster	Yes/No	_____	_____

ADDICTION HISTORY

Please check any past or present addictions/substance abuse problems.
Alcohol_____ Drugs_____ Pornography_____ Shopping/spending_____
Gambling_____ Food_____ Other (Explain)_____

Have you ever received treatment for addictions or substance abuse? □ Yes □ No
If so, when and where?

Criminal history: □ Yes □ No □ Arrested □ Convictions □ Incarceration
Reason for legal action_____
If incarcerated when, where, and how long?_____

EMPLOYMENT HISTORY

Are you currently employed? □ Yes □ No

If yes, what is the name of your current employer? _____

What is your position? _____ Number of hours you work per week: _____

Length of employment: _____Do you enjoy your work? □ Yes □ No What type of stressors

(if any) do you experience at work?_____

If not currently unemployed, how long unemployed? _____What was your previous position?

_____

Reason for termination:_____

EDUCATION HISTORY

What is your highest level of education completed?

□ H.S. graduate □ Some college □ 4 year degree □ Master's degree □ Ph.D.

RELIGIOUS/SPIRITUAL INFORMATION

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

If yes, describe your faith or spiritual belief.

Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc?) □ Yes □ No If yes, please describe your current level of connection and involvement:

_____

Do you wish to incorporate your faith/spirituality into the counseling process. □ Yes □ No

If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction: _____

_____

TREATMENT PLAN

Please complete this form as best you can. If you are unsure of your answers bring in your questions and complete the treatment plan together.

1. Problems (Why am I here?)

_____
_____
_____
_____

2. Goals (What do I want to accomplish?)

_____
_____
_____
_____
_____

3. How will I know I am making progress?

_____
_____
_____
_____

4. Please list any additional comments or information you would like your therapist to know.

_____
_____
_____

This section to be filled out by client and therapist

Diagnosis Code_____Description_____

Approximate time it will take to accomplish goals: _____
Types of interventions/therapy to be used by the therapist_____
_____
_____
_____
_____

I agree to fully participate in the therapy process as directed by my therapist using the above mentioned interventions to accomplish my goals.

_____ _____ _____ _____

Client Signature **Date** **Therapist Signature** **Date**