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's name? _____How long married? _____

Number of marriages_____ Number of divorces_____ If widowed, your age at death of spouse_____

If you are currently in a relationship or partnership, please list the name of the person:_____

Length of time you've known each other: _____Length of time you have been together_____

Do you currently live together? □ Yes □ No

Please list any children

Name	Age	Lives with you	Name	Age	Lives with you

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? □ No □ Yes,

Name of practitioner	Date of services	Diagnosis	Reason for termination

Are you currently taking any psychiatric prescription medication? □ Yes □ No

Current medication	Dosage	For how long?	Purpose	Physicians Name

Have you ever been hospitalized for mental concerns? □ Yes □ No

GENERAL HEALTH & MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

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? (Please circle)
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? □ No □ Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes If yes, where is the pain and when did you begin experiencing this? _____

_____

8. Do you drink alcohol? □ No □ Yes If yes, how much & how often?_____
Has anyone ever told you they were concerned about your frequent use of alcohol? □ No □ Yes

_____

9. How often do you engage in recreational drug use? Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____ (10 being the best)

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

_____

_____

10. Have you ever, or are you currently engaging in self-harm? Currently _____ Past_____

11. Have you ever, or are you currently contemplating suicide? Currently_____ Past_____

HAVE YOU EVER EXPERIENCED?

	Please circle	Comments
Extreme Depressed Mood	Yes/No	_____
Wild Mood Swings	Yes/No	_____
Rapid Speech	Yes/No	_____
Extreme Anxiety	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	_____
Alcohol/Substance Abuse	Yes/No	_____
Frequent Body Complaints	Yes/No	_____
Eating Disorder	Yes/No	_____
Body Image Problems	Yes/No	_____
Repetitive Thoughts/Obsessions	Yes/No	_____
Homicidal Thoughts	Yes/No	_____
Suicide Attempt	Yes/No	_____
Repetitive Behaviors (frequent checking, hand washing, etc.)	Yes/No	_____

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 members relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety Disorders	yes/no	_____
Autism/Asperger Syndrome	yes/no	_____
Depression	yes/no	_____
Difficult family member	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Trauma History	yes/no	_____
Other mental disorder (please list)	yes/no	_____

OCCUPATIONAL INFORMATION

1. Are you currently employed? □ No □ Yes
If no, how long unemployed? _____What was your previous position? _____
Reason for termination:_____
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? □ No □ Yes What type of stressors (if any) do you experience at work? _____

RELIGIOUS/SPIRITUAL INFORMATION

1. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or spiritual belief.

_____

_____

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

_____

_____

_____

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

_____
_____
_____

Diagnosis Code_____Description_____

This section to be filled out by client and therapist

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 abovementioned interventions to accomplish my goals.

_____ _____ _____ _____

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