SPECTRUM COUNSELING

I N T A K E F O R M

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

Birth Date: _____ /_____ /_____ Age: _____ Gender: ____Male ____Female ____ Other
Referred by (if any): _____Relationship_____
Emergency Contact Person_____Phone number_____Relationship_____

RELATIONSHIP INFORMATION

Check Marital Status: ___ Married ___ 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 ___yes ___no Name _____ Age____Lives with you ____yes ____no
Name_____ Age____Lives with you ___yes ___no Name _____ Age____Lives with you ____yes ____no
Name_____ Age____Lives with you ___yes ___no Name _____ Age ____ Lives with you ____yes ____no

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

Psychiatrist Name _____Address_____Phone_____

Current psychiatric medication	Dosage	For how long?	Purpose	Physicians Name
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been hospitalized for mental concerns? ____Yes ____ No
If so, when?_____where?_____Reason for hospitalization_____
_____

GENERAL HEALTH INFORMATION

Primary Care Physician_____Address _____Phone_____
1. How would you rate your current physical health? Please check.
_____ Poor _____ Unsatisfactory _____ Satisfactory _____ Good _____ Very good
Please list any specific health problems you are currently experiencing (include illnesses & allergies)
_____
_____

2. How would you rate your current sleeping habits? Please check.
_____ 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. Have you ever served in the military? No Yes 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? _____No _____Yes
_____

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

10. Any addictions or substance abuse?
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? _____
_____
_____
12. Have you ever, or are you currently engaging in self-harm? Currently _____ Past_____
13. Have you ever, or are you currently contemplating suicide? Currently _____ Past_____

HAVE YOU EVER EXPERIENCED?

	Please check	Comments
Addictions/Substance Abuse	Yes___No___	_____
Adoption	Yes___No___	_____
Autism/Aspergers	Yes___No___	_____
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___	_____
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___	_____
<u>Trauma history</u>		
Physical abuse	Yes___No___	_____
Emotional Abuse	Yes___No___	_____
Sexual Abuse	Yes___No___	_____
Verbal abuse	Yes___No___	_____
Natural disaster	Yes___No___	_____

ADDICTION HISTORY

Any addictions or substance abuse? Please check.
_____Pornography _____Shopping/spending _____Gambling _____ Food
_____Other (Explain)_____

Have you received treatment for any addictions or substance abuse? _____Yes _____No
If so, when, where, and for how long?_____
_____
Criminal History ___Yes ____ No _____ Arrested _____ Convictions _____ Incarceration
_____
If incarcerated, when, where, and for how long?_____

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 check	Please List Family Member(s)
Adoption history	yes___no___	_____
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___	_____

EDUCATION/EMPLOYMENT HISTORY

1. 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 no, how long unemployed? _____What was your previous position? _____
Reason for termination:_____

2. What is your highest level of education completed? Please check.
_____H.S. graduate _____ Some college _____ 4 year degree ____ Master's degree _____ Ph.D

RELIGIOUS/SPIRITUAL INFORMATION

1. Do you consider yourself to be a spiritual or religious person? _____Yes _____No
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? _____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 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.

_____	_____	/S/ *Mary Einarson*
Client Signature	**Date**	**Therapist Signature**