

INTAKE FORM

Welcome to Link Therapy & Mediation. These forms will give you the chance to describe your situation and history. Please fill them out as completely as possible and have them ready before your first counseling session.

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ Male Female

Address: _____

Occupation: _____

Employer (if employed): _____

School (if student): _____

Phone (h): _____ Messages ok at home? Yes No

Phone (cell): _____ Messages ok on cell? Yes No

Phone (w): _____ Messages ok at work? Yes No

Email: _____ Email messages okay? Yes No

Note: I cannot guarantee the confidentiality of email.

How did you find out about Link Therapy & Mediation? _____

Religious Affiliation (if applicable): _____

Ethnic/Cultural Heritage: _____

INSURANCE INFORMATION (if applicable)

Primary Insurance Carrier _____

Social Security Number: _____ - _____ - _____ ID #: _____ Group #: _____

Name of Policy Holder: _____ DOB: _____

Address of Policy Holder: _____

MARITAL STATUS

Single Engaged Married (legally) Divorced Total # of Marriages: _____

Cohabiting Divorce in process Separated Widowed

Assessment of current relationship (if applicable) Good Fair Poor

FAMILY INFORMATION

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Type (bio,step,etc)</u>	<u>Living with you?</u>
Mother	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/SO	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children/Siblings	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION

Total years of education: _____ Currently enrolled: Yes No

Please fill in number of years:

_____ High School/GED _____ College _____ Vocational _____ Graduate School

Other training: _____

Special circumstances: _____

MILITARY

Military experience? Yes No Combat experience? Yes No

Where: _____ Branch: _____ Length of Service _____

Type of discharge: _____ Rank at discharge: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

What personal qualities would others say you have?

Describe your support system—influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life.

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No If so, where: _____

Approximate Dates of Counseling: _____

For what reason? _____

Do you have a previous mental health diagnosis: _____

What did you find **most helpful** in therapy?

What did you find **least helpful** in therapy?

Please describe your past and current use of drugs and alcohol and any time spent in treatment:

Have you taken medication for a mental health concern? Yes No

Name and dosage of medication	Dates Taken	Helpful?(Y/N)
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have other medical concerns or previous hospitalizations? Please describe.

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you/your child/adolescent need counseling?

What would you like to see happen as a result of counseling?

FAMILY HISTORY

Who lived in your home when you were a child? _____

What is your birth order? _____

What word would you use to describe your family of origin? _____

Did/do you have any significant issues with someone in your family? Please describe.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

How old were you when you left home and what were the circumstances?

FAMILY CONCERNS

Please check any family concerns that you are having.

- | | | |
|--|---|--|
| <input type="checkbox"/> Fighting | <input type="checkbox"/> Death of family member | <input type="checkbox"/> Parental overprotection |
| <input type="checkbox"/> Feeling distant | <input type="checkbox"/> Health problems of family member | <input type="checkbox"/> Abuse/neglect |
| <input type="checkbox"/> Lack of honesty | <input type="checkbox"/> Alcoholism of a family member | <input type="checkbox"/> Discord with siblings |
| <input type="checkbox"/> Physical fights | <input type="checkbox"/> Drug use | <input type="checkbox"/> Inadequate housing or unsafe neighborhood |
| <input type="checkbox"/> Education problems | <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Inadequate health insurance or access to healthcare |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Birth of a child | <input type="checkbox"/> Job change or dissatisfaction |
| <input type="checkbox"/> Disagreeing about relatives | <input type="checkbox"/> Divorce/separation | |
| <input type="checkbox"/> Infidelity (Couple) | <input type="checkbox"/> Remarriage (self or parent) | |
| <input type="checkbox"/> Disagreeing about friends | | |

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Sadness/Depression					Increased or decreased appetite				
Crying					Unplanned weight gain				
Sleep disturbances					Unplanned weight loss				
Dissociation					Paranoid thoughts				
Hyperactivity					Poor concentration/indecisive				
Bingeing/Purging					Low energy				
Decreased sex drive					Excessive worrying				
Unresolved guilt					Low self-worth				
Irritability					Anger management problems				
Nausea/Acid indigestion					Spiritual concerns				
Social anxiety					Hallucinations				
Self-mutilation/cutting					Racing thoughts				
Impulsivity					Restlessness				
Nightmares					Loss of interest in normal activity				
Elevated mood					Decreased creativity/productivity				
Losing train of thought					Unresolved anger				
Mood swings					Easily distracted				
Disorganized					Memories of trauma/flashbacks				
Anorexia					Hopelessness				
Social isolation					Work issues				
Phobia(s)					Problems at home				
Obsessive thoughts					Panic attacks				
Grief					Feel panicky/anxious				
Headaches					Suicidal thoughts				
Loneliness					Has attempted suicide in the past				

ADDITIONAL INFORMATION

Is there anything else you would like to share:

Client Signature

Date

Parent (or guardian) Signature

Date