Family Help Counseling and Seminars

Mary J. Lambrecht, M.S., LMFT

Adult Intake Information

Client's name: ______________________________ Date: ____________

Gender: ___ F ___ M Date of birth: ________ Age: ____________

Form completed by (if someone other than client): ______________________________

Primary reason(s) for seeking services:

__ Marital Problems ____ Parenting ____ Relationship ____ Family

__ Anger management ____ Anxiety ____ Coping ____ Depression

__ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

__ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs ____ Eating Habits

__ Job ____ Medical / Health problems

__ Other mental health concerns (specify): ______________________________

*If you need any more space for any of the questions please use the back of the sheet.

Marital Status

(more than one answer may apply)

____ Single

____ Divorce in process
Length of time: _______

____ Unmarried, living together
Length of time: _______

____ Legally married
Length of time: _______

____ Separated
Length of time: _______

____ Divorced
Length of time: _______

____ Widowed
Length of time: _______

____ Annulment
Length of time: _______

Total number of marriages: ____

Religious/Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ______________________________

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ___ No

If Yes, describe: ______________________________

Other cultural/ethnic information: ______________________________

Would you like your spiritual/religious beliefs incorporated into your counseling? ____ Yes ____ No

If Yes, describe: ______________________________

Do you have a religious affiliation? _____Yes ____No

If Yes, please explain: ______________________________

Legal

Are you involved in any criminal proceedings or litigation at the present time? ____ Yes ____ No

If Yes, please describe: ______________________________

____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: ______________________________

Education

Level of education completed: ____GED ____ High School ____ Some College

____ Associate __ Bachelors ____ Masters ____PhD ____ Other

Ex: ____________

Currently enrolled in school? ____ Yes ____ No

If Yes, where: ____

Special circumstances (e.g., learning disabilities, gifted): ______________________________

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No

Where: ____

Branch: ______________________ Discharge date: ____________________

Type of discharge: ____

Family Information

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brothers, sisters, grandparents, step-relatives/half-relatives. Please specify relationship.)

Medical/Physical Health

___AIDS
___Alcoholism
___Abortion
___Anemia
___Bladder control
___Cancer
___Chronic pain
___Dizziness
___Diabetes

___Drug abuse
___Epilepsy
___Eating problems
___Fatigue
___Hepatitis
___Headaches/Migraines
___High blood pressure
___Mononucleosis
___Miscarriages

___Nausea
___Neurological disorders
___Sexual problems
___Sleeping disorders
___Stomach aches
___Sexually transmitted
___diseases
___Thyroid problems
___Vomiting

___Other (describe): ____

List any current health concerns: ______________________________________

List any recent health or physical changes: ________________________________

____

Current prescribed medications	Dose	Length of Time	Purpose	Side effects
____________	____	____	____________	____________
____________	____	____	____________	____________
____________	____	____	____________	____________

Current over-the-counter meds	Dose	Length of Time	Purpose	Side effects
____________	____	____	____________	____________
____________	____	____	____________	____________
____________	____	____	____________	____________

Family history of medical problems: ____

____

Please check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: ____________________________

____

Please tell us about your prior counseling and/or treatment history:

	Yes	No	When	Where	Reason / Diagnosis
Counseling/Psychiatric treatment	___	___	________	____________	____________
Suicidal thoughts/attempts	___	___	________	____________	____________
Drug/alcohol treatment	___	___	________	____________	____________
Hospitalizations	___	___	________	____________	____________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	________	____________	____________

Have any of your family members or significant others had counseling or treatment in any of the above areas?

____

____

Do you drink alcohol? ____ Yes ____ No If so, how often and in what quantity? ____________

____

Have you used/abused drugs, alcohol or controlled substances? ____ Yes ____ No If yes, please explain:

____

____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

__ Yes ___ No If Yes, describe: ________________________________

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: ____

Have drugs or alcohol created a problem for your job/relationship? ____ Yes ____ No

If Yes, describe: ____

Behavioral History

Please check behaviors and symptoms that are problematic for you:

__ Aggression	___ Phobias/fears	___ Panic attacks
__ Alcohol dependence	___ Fatigue	___ Pornography
__ Anger	___ Gambling	___ Disruptive thoughts
__ Hallucinations	___ Sexual addiction	___ Spending problems
__ Anxiety	___ Heart palpitations	___ Sexual difficulties
__ Avoiding people	___ High blood pressure	___ Sleeping problems
__ Chest pain	___ Hopelessness	___ Speech problems
__ Cyber addiction	___ Impulsivity	___ Suicidal thoughts
__ Depression	___ Irritability	___ Disorganized thoughts
__ Disorientation	___ Judgment errors	___ Trembling
__ Distractibility	___ Loneliness	___ Withdrawing
__ Dizziness	___ Memory impairment	___ Worrying
__ Drug dependence	___ Mood shifts	___ Social problems
__ Eating disorder	___ Hyperactivity	___ Other (specify): ________

Briefly discuss how the above symptoms impact your ability to function: ______________________

____

____

____

____

____

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

_____Yes _____ No If Yes, please explain:

____

____

____

Stress Indicators

Were there special, unusual, or traumatic circumstances that affected you in childhood? ____Yes ____No

(i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)

If Yes, please describe:

____

____

____

Please check any events that have occurred in the last 12 months:

____ Moving	____ Divorce	___ Financial Problems
____ Marriage	____ Car trouble	___ Birth of a child
____ Natural disaster	____ Job Change	___ Death of a close family member/friend

COUNSELING GOALS:

WHAT WOULD YOU LIKE TO SEE ACCOMPLISHED IN YOUR COUNSELING?

1. ____

   ____

2. ____

   ____

3. ____

   ____

4. ____

   ____