Grace Counseling Clinical Intake Form

Name____ Today's Date ___________________

PRESENTING PROBLEMS-Why are you coming to counseling?

Main problems ____ ____ ____

Duration (months) ____________________ ____________________ ____________________

Additional information:

Visual	Auditory	Kinetic
Concrete	Sequential	Global
Abstract	Random	Analytical

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[ ]	[ ]	[ ]	[ ]	binging/purging	[ ]	[ ]	[ ]	[ ]	guilt	[ ]	[ ]	[ ]	[ ]
appetite disturbance	[ ]	[ ]	[ ]	[ ]	laxative/diuretic abuse	[ ]	[ ]	[ ]	[ ]	elevated mood	[ ]	[ ]	[ ]	[ ]
sleep disturbance	[ ]	[ ]	[ ]	[ ]	anorexia	[ ]	[ ]	[ ]	[ ]	hyperactivity	[ ]	[ ]	[ ]	[ ]
suicidal thoughts	[ ]	[ ]	[ ]	[ ]	paranoid thoughts	[ ]	[ ]	[ ]	[ ]	out of touch-dissociative states	[ ]	[ ]	[ ]	[ ]
fatigue/low energy	[ ]	[ ]	[ ]	[ ]	mania/manic symptoms	[ ]	[ ]	[ ]	[ ]	physical complaints	[ ]	[ ]	[ ]	[ ]
physical retardation	[ ]	[ ]	[ ]	[ ]	loose associations	[ ]	[ ]	[ ]	[ ]	self-mutilation	[ ]	[ ]	[ ]	[ ]
poor concentration	[ ]	[ ]	[ ]	[ ]	delusions	[ ]	[ ]	[ ]	[ ]	significant weight gain/loss	[ ]	[ ]	[ ]	[ ]
poor grooming	[ ]	[ ]	[ ]	[ ]	hallucinations	[ ]	[ ]	[ ]	[ ]	co-existing medical condition	[ ]	[ ]	[ ]	[ ]
mood swings	[ ]	[ ]	[ ]	[ ]	aggressive behaviors	[ ]	[ ]	[ ]	[ ]	emotional trauma victim	[ ]	[ ]	[ ]	[ ]
agitation	[ ]	[ ]	[ ]	[ ]	conduct problems	[ ]	[ ]	[ ]	[ ]	physical trauma victim	[ ]	[ ]	[ ]	[ ]
emotionality	[ ]	[ ]	[ ]	[ ]	oppositional behavior	[ ]	[ ]	[ ]	[ ]	sexual trauma victim	[ ]	[ ]	[ ]	[ ]
irritability	[ ]	[ ]	[ ]	[ ]	sexual dysfunction	[ ]	[ ]	[ ]	[ ]	emotional trauma perpetrator	[ ]	[ ]	[ ]	[ ]
general anxiety	[ ]	[ ]	[ ]	[ ]	grief	[ ]	[ ]	[ ]	[ ]	physical trauma perpetrator	[ ]	[ ]	[ ]	[ ]
panic attacks	[ ]	[ ]	[ ]	[ ]	hopelessness	[ ]	[ ]	[ ]	[ ]	sexual trauma perpetrator	[ ]	[ ]	[ ]	[ ]
phobias	[ ]	[ ]	[ ]	[ ]	social isolation	[ ]	[ ]	[ ]	[ ]	substance abuse	[ ]	[ ]	[ ]	[ ]
obsessions/compulsions	[ ]	[ ]	[ ]	[ ]	worthlessness	[ ]	[ ]	[ ]	[ ]	other (specify) ___________	[ ]	[ ]	[ ]	[ ]

SPIRITUAL HISTORY

Current Church attending: ____ Church attendance per month (circle) 0 1 2 3 4 5 6 7 8 9 10 10+

Denominational preference: ___________________________________ Membership: ______________________________

Church attended in childhood: ________________________ Baptized? Yes _____ No _____ When? ________________

Do you pray to God? Never____ Occasionally ____ Often ____ How frequently do you read the Bible? Never ____ Occasionally ____ Often ____

Do you have regular personal devotions? Yes ____ No ____ Do you have regular family devotions? Yes ____ No ____

Explain any recent changes in your religious life:____

Are you saved? Yes _____ No _____ Not sure what you mean _____

Describe your personal understanding of how someone has a relationship with God ____
____

Describe how to be controlled by the Holy Spirit ____
____

Would you describe yourself as a growing___ struggling___ stagnant___ young___ mature___ disillusioned___ Christian? Other?_____________________

Summarize what you believe is your relationship with God.____
____

EMOTIONAL/ PSYCHIATRIC HISTORY

[ ] [ ] **Prior outpatient psychotherapy?**
No Yes If yes, on _______occasions. Longest treatment by ______________ (Provider Name) for _____ sessions from ____/_______ (Month/Year) to _____/_______ (Month/Year)

Prior provider name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
__________________	____________	______	___________	___________	___________________	____________________
__________________	____________	______	___________	___________	___________________	____________________

[ ] [ ] **Has any family member had outpatient psychotherapy?** If yes, who/why (list all):____
No Yes ____

[ ] [ ] **Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?**
No Yes If yes, on _______occasions. Longest treatment at _______________________________ (Name of facility) from ___/_______ (Month/Year) to _____/_______ (Month/Year)

Inpatient facility name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
________________	__________	_____	_________	_________	_________________	__________________
________________	__________	_____	_________	_________	_________________	__________________

[ ] No [ ] Yes **Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?** If yes, who/why (list all):____

[ ] No [ ] Yes **Personal Prior or Current Psychotropic Medication Usage?** If yes:

Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?
__________	_____	________	________	______	______________	__________	________________
__________	_____	________	________	______	______________	__________	________________
__________	_____	________	________	______	______________	__________	________________

[ ] No [ ] Yes **Has any family member used psychotropic medications?** If yes, who/what/why (list all):______________________________
____

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

____

Parents' current marital status:

[ ] married to each other
[ ] separated for ____ years
[ ] divorced for ___ years
[ ] mother remarried ___ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
[ ]age of patient at mother's death ___
[ ] father deceased for ___ years
age of patient at father's death ___

Describe parents:

	Father	**Mother**
full name	______________	______________
occupation	______________	______________
education	______________	______________
general health	______________	______________

Describe childhood family experience:

[ ] outstanding home environment
[ ] normal home environment
[ ] chaotic home environment
[ ] witnessed physical/verbal/sexual abuse toward others
[ ] experienced physical/verbal/sexual abuse from others

Age of emancipation from home: ___________ **Circumstances:** ____
____
____

Special circumstances in childhood:____
____
____

IMMEDIATE FAMILY

Marital status:

[ ] single, never married
[ ] engaged ____ months
[ ] married for ____ years
[ ] divorced for ___ years
[ ] separated for ___ years
[ ] divorce in process ____ months
[ ] live-in for ____ years
[ ] ___ prior marriages (self)
[ ] ___ prior marriages (partner)

Intimate relationship:

[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:

[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to patient
______________	____	____	__________________
______________	____	____	__________________
______________	____	____	__________________

List children not living in same household as patient:

______________	____	____	__________________
______________	____	____	__________________
______________	____	____	__________________

Frequency of visitation of above: ____________________

Describe any past or current significant issues in intimate relationships: ____________________________________
____
____

Describe any past or current significant issues in other immediate family relationships: ________________________
____
____

MEDICAL HISTORY (check all that apply for the client)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor
____

List name of primary care physician:
Name ______________________ Phone ______________

List name of psychiatrist: (if any):
Name ______________________ Phone ______________

What is the date of your last physical? ______________________

Is there a history of any of the following in the family:

[ ] tuberculosis
[ ] birth defects
[ ] emotional problems
[ ] behavior problems
[ ] thyroid problems
[ ] cancer
[ ] mental retardation
[ ] heart disease
[ ] high blood pressure
[ ] alcoholism
[ ] drug abuse
[ ] diabetes
[ ] Alzheimer's disease/dementia
[ ] stroke

List any medications currently being taken (give dosage & reason): ____
____
____

[ ] other chronic or serious health problems ____________________
____

Describe any serious hospitalization or accidents:____

Date _________ Age _____ Reason ____________________
Date _________ Age _____ Reason ____________________
Date: _________ Age _____ Reason ____________________

List any known allergies: ___________________________

List any abnormal lab test results:
Date ____________ Result ______________________
Date ____________ Result ______________________

SUBSTANCE USE HISTORY (check all that apply for the client)

Family alcohol/drug abuse history:

[ ] father
[ ] mother
[ ] grandparent(s)
[ ] sibling(s)
[ ] other ____________________
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] spouse/significant other
[ ] children

Substance use status:
[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used: (complete all that apply)	**First use age**	**Last use age**	**Current Use (Yes/No)**	**Frequency**	**Amount**
[ ] alcohol	________	________	______	_______	______
[ ] amphetamines/speed	________	________	______	_______	______
[ ] barbiturates/owners	________	________	______	_______	______
[ ] caffeine	________	________	______	_______	______
[ ] cocaine	________	________	______	_______	______
[ ] crack cocaine	________	________	______	_______	______
[ ] hallucinogens (e.g., LSD)	________	________	______	_______	______
[ ] inhalants (e.g., glue, gas)	________	________	______	_______	______
[ ] marijuana or hashish	________	________	______	_______	______
[ ] nicotine/cigarettes	________	________	______	_______	______
[ ] PCP	________	________	______	_______	______
[ ] prescription____________	________	________	______	_______	______
[ ] other_________________	________	________	______	_______	______

Treatment history:
[ ] outpatient (age[s]______________)
[ ] inpatient (age[s]________________)
[ ] 12-step program (age[s]__________)
[ ] stopped on own (age[s]__________)
[ ] other (age[s]___________________
[ ] other (describe) ____

Consequences of substance abuse (check all that apply):
[ ] hangovers
[ ] seizures
[ ] blackouts
[ ] overdose
[ ] withdrawal symptoms
[ ] medical conditions
[ ] tolerance changes
[ ] loss of control amount used
[ ] sleep disturbance
[ ] assaults
[ ] suicidal impulse
[ ] relationship conflicts
[ ] binges
[ ] job loss
[ ] arrests

DEVELOPMENTAL HISTORY (check all that apply for the client)

Problems during mother's pregnancy:
[ ] none
[ ] high blood pressure
[ ] kidney infection
[ ] German measles
[ ] emotional stress
[ ] bleeding
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:
[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications ______
____
birth weight ____lbs ___oz.

Infancy:
[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems

Childhood health:
[ ] chickenpox (age __________)
[ ] German measles (age _____)
[ ] red measles (age __________)
[ ] rheumatic fever (age ______)
[ ] whooping cough (age _____)
[ ] scarlet fever (age _________)
[ ] autism
[ ] ear infections
[ ] lead poising (age ________)
[ ] mumps (age ____________)
[ ] diphtheria (age __________)
[ ] poliomyelitis (age _______)
[ ] pneumonia (age _________)
[ ] tuberculosis (age ________)
[ ] mental retardation
[ ] asthma
[ ] allergies to ____
[ ] significant injuries ____
[ ] chronic, serious health problems ________________________________

Delayed developmental milestones (check only those milestones that did not occur at expected age):
[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] feeding self
[ ] speaking words
[ ] speaking sentences
[ ] controlling bladder
[ ] other ________________________________
[ ] controlling bowels
[ ] sleeping alone
[ ] dressing self
[ ] engaging peers
[ ] tolerating separation
[ ] playing cooperatively
[ ] riding tricycle
[ ] riding bicycle

Emotional / behavior problems (check all that apply):
[ ] drug use
[ ] alcohol abuse
[ ] chronic lying
[ ] stealing
[ ] violent temper
[ ] fire-setting
[ ] hyperactive
[ ] animal cruelty
[ ] assaults others
[ ] disobedient
[ ] repeats words of others
[ ] not trustworthy
[ ] hostile/angry mood
[ ] indecisive
[ ] immature
[ ] bizarre behavior
[ ] self-injurious threats
[ ] frequently tearful
[ ] frequently daydreams
[ ] lack of attachment
[ ] distrustful
[ ] extreme worrier
[ ] self-injurious acts
[ ] impulsive
[ ] easily distracted
[ ] poor concentration
[ ] often sad
[ ] breaks things
[ ] other _____________
____

Social interaction-check all that apply **(See next page also)**
[ ] normal social interaction
[ ] inappropriate sex play

Intellectual / academic functioning-check all that apply (**See next page also)**
[ ] normal intelligence
[ ] authority conflicts
[ ] mild retardation

[ ] isolates self
[ ] very shy
[ ] alienates self
[ ] dominates others
[ ] associates with acting-out peers
[ ] other ____________________
[ ] high intelligence
[ ] learning problems
[ ] attention problems
[ ] underachieving
[ ] moderate retardation
[ ] severe retardation
Current or highest education level ______________________________________

Describe any other developmental problems or issues: ____

GENERAL HISTORY (check all that apply for the client)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin

Sexual history:
[ ] heterosexual orientation
[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] currently sexually satisfied
[ ] currently sexually dissatisfied
[ ] age first sex experience _______
[ ] age first pregnancy/fatherhood ___
[ ] history of promiscuity age ___ to ___
[ ] history of unsafe sex age __ to ___
Additional information: ______________________________________

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] unstable work history
[ ] disabled: __________________

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty or below-poverty income
[ ] impulsive spending
[ ] relationship conflicts over finances

Military history:
[ ] never in military
[ ] served in military - no incident
[ ] served in military - **with** incident
____

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison __________ time(s)
total time served: ________
describe last legal difficulty: ____
____

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): ________________________
____
describe any cultural issues that contribute to current problem: _______
____
currently active in community/recreational activities? Yes [ ] No [ ]
formerly active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _______________________
____

Educational History:
Highest grade:____
Major in College:____
Currently in education with what goal:_________________________
____

PERSONALITY INFORMATION Circle the following words that best describe you now. Please pick ONE PER LINE from each column. YOU SHOULD HAVE 10 CIRCLES WHEN YOU ARE DONE.

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
1. Forceful	Talkative	Steady	Precise
2. Bossy	Brassy	Blank	Bashful
3. Decisive	Sociable	Accommodating	Analytical
4. Unsympathetic	Disorganized	Unenthusiastic	Introvert
5. Mover	Bouncy	Listener	Scheduled
6. Domineering	Loud	Aimless	Depressed
7. Adventurous	Cheerful	Patient	Musical
8. Powerful	Persuasive	Peaceful	Perfectionist
9. Stubborn	Show-off	Slow	Skeptical
10.Lion	Otter	Golden Retriever	Beaver

PROJECTS ARE EXPECTED TO BE COMPLETED.
PAYMENT IS TO BE MADE AT THE TIME OF THE APPOINTMENT.
CANCELLATIONS MADE WITHIN 24 HOURS REQUIRE HALF PAYMENT FOR THE APPOINTMENT.

______________________________________ ______________________________
Signature **Date**