

Center for Transformative Counseling, Inc.

801 Georgia Street
Key West, FL 33040
305-407-7676

Counseling Intake

Identifying Information

Name _____
Nickname/Name you want to be called _____
Address _____

Phone Numbers (home, work, cell) _____
Email Address _____
Date of Birth _____
Gender _____
Ethnicity _____
Marital/partnership status _____
Close friend/relative we may contact in case of an emergency _____
Relationship to you _____
Address _____
Phone Number _____
Referred by _____

**Note: If you need more space to answer any of the questions below, please use the back of the sheet, indicating the question number you are responding to.*

Current Social Information

1. Describe your present living arrangements (with whom do you live) and briefly describe these relationships _____

2. How long have you been married/dating/living together? Describe this relationship (include occupation and age of significant other) _____

3. How many children do you have? (Name, sex, age) _____

4. Are there any significant problems with any of these children? (Describe)____

5. Give details of previous relationships/marriages_____

6. Any history of abuse (emotional, physical, sexual, verbal) in current or previous relationships_____

Family History

7. Describe your childhood and adolescence (include home atmosphere, relationship with parents)_____

8. Significant life events_____

9. List mother and father by name, age, occupation_____

10. List siblings by name and age and describe how you relate to them (past and present)_____

11. Have any family members been treated for/have emotional problems? Describe

Loss History

12. List type and dates of any traumatic losses (death, serious illness/disability, divorce, separation, job loss, retirement, loss of home/relocation)_____

13. List type and dates of other changes that resulted in loss (moving, graduation, abuse, change in social status and/or friendships, etc.)_____

Spiritual History

14. Religious affiliation history_____

15. Describe views on spirituality (God, life after death, meaning of life, connection with something greater than self, etc.)_____

Substance Abuse History

16. Any family history of drug and/or alcohol usage? List and describe_____

17. Any personal history of drug/alcohol usage? List and describe _____

18. Describe any change in your pattern of drug/alcohol usage in the past 6 months to 1 year_____

19. Have you ever had a DUI? No____ Yes____
If more than one, how many?_____

Medical History

20. Describe any previous experiences with psychiatrists and/or counselors_____

21. Describe any illnesses you have presently and give the name of your attending physician_____

22. What prescription medications are you taking_____

Educational History

23. Last degree and major or grade completed_____

24. Where did you go to school (high school, college, vocational, etc.)_____

25. Describe your school experience (was it positive or problematic, truancy, suspensions, special education, gifted program, etc.)_____

Employment History

26. Present employment status and where (include positive and negative aspects of what is going on at work)_____

27. Present income_____

28. If on leave of absence or disability, will you return to present job?_____

Social Activities and Interests

29. List clubs and organizations you belong to_____

30. What do you do for fun and/or relaxation_____

31. Skills/strengths/talents _____

Self-Assessment

32. Check all that apply to you:

- | | |
|--------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling that you are not real |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Feeling that things around you are not real |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Lose track of time |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger/frustration |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Defy rules/authority |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Blame others |
| <input type="checkbox"/> Sleep disturbance (more/less) | <input type="checkbox"/> Argue |
| <input type="checkbox"/> Appetite disturbance (more/less) | <input type="checkbox"/> Excessive use of drugs and/or alcohol |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Excessive use of prescription medications |
| <input type="checkbox"/> Thoughts of hurting yourself | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Thoughts of hurting someone | <input type="checkbox"/> Physical abuse issues |
| <input type="checkbox"/> Isolation/social withdrawal | <input type="checkbox"/> Sexual abuse issues |
| <input type="checkbox"/> Sadness/loss | <input type="checkbox"/> Spousal abuse issues |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Feeling vulnerable/unsafe |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Loneliness/emptiness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Overwhelmed |
| <input type="checkbox"/> Panic | <input type="checkbox"/> Afraid |
| <input type="checkbox"/> Heart pounding/racing | <input type="checkbox"/> Emotionally numb |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Trembling/shaking/dizziness | <input type="checkbox"/> Over-protective |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Resentful |
| <input type="checkbox"/> Chills/hot flashes | <input type="checkbox"/> Frequent illnesses/accidents |
| <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> Hypervigilant/startle easily |
| <input type="checkbox"/> Fear of dying | <input type="checkbox"/> Restless/constantly busy |
| <input type="checkbox"/> Fear of going crazy | <input type="checkbox"/> Feeling lost |
| <input type="checkbox"/> Fear of being alone | <input type="checkbox"/> Spiritual questioning |
| <input type="checkbox"/> Nausea | |
| <input type="checkbox"/> Phobias | |
| <input type="checkbox"/> Obsessions/compulsive behaviors | |
| <input type="checkbox"/> Thoughts racing | |
| <input type="checkbox"/> Easily distracted/can't hold onto an idea | |
| <input type="checkbox"/> Easily agitated/annoyed | |
| <input type="checkbox"/> Excessive behaviors (spending, gambling) | |
| <input type="checkbox"/> Delusions/hallucinations | |
| <input type="checkbox"/> Confusion/not thinking clearly | |

Present Situation

33. What/who seems to be placing the most stress on you right now? _____

34. Are there any legal issues pending? No____ Yes____ Describe_____

35. Are you having any financial problems at this time?_____

36. What would you like to accomplish in therapy?_____

37. Is there anything important that we have not asked?_____

Type of Therapy

38. What kind of therapy would you prefer? (You may indicate more than one choice.)

____ Online Chat Therapy

____ Email Therapy

____ Telephone or WebCam Therapy

____ Face to Face (available in Key West, FL area only)

I hereby avow that I am 18 years old or over and will present ID upon request.

Client Signature

Date

If you are under 18 years old, parent/guardian signature is required.

Parent/Guardian Name_____

Relationship to Minor_____

Date_____

Signature_____