Restore and Rebuild Counseling

...helping individuals and families thrive

Intake Form

Name _____ Today's Date _____

Address _____ City _____ Zip _____

Phone: Home _____ Work _____ Cell _____
Check for Yes – May we call you at: H _____ W _____ C _____
Check for Yes – May we identify ourselves: H _____ W _____ C _____

E-mail address:_____ Check if we can contact you by email:____
Age _____ Birth Date _____ Place of Birth _____
Church/Religion _____ Race/Ethnicity _____
Employer _____ Occupation _____
How did you hear about us? _____ May we thank that person? _____
Emergency Contact _____
Name Relationship Phone Number

Reason you are seeking counseling today _____
_____
_____
_____

Marital Status (please check one, and fill in detail if applicable)
Single_____ **Living with Significant Other**_____ how long together_____
Engaged_____wedding date_____ how long together_____
Married ____ years married_____ number of previous marriages_____
Separated _____ how long_____ **Divorced** _____ date _____
Widowed _____how long _____
Name of spouse or significant other _____
Describe your relationship _____
_____
_____

Children (if more than 4 please list on back of page)

Name	Relationship	Age	Sex	Living at home?

Who has legal custody of your children?_____

Describe what it is like to live in your household today._____
_____
_____
_____

Describe your family and household when you were growing up._____

Are there any current addictions or history of addictions in you or immediate/extended family members (drugs, alcohol, sex, gambling, eating, pornography, prescription drugs, work, or other)? _____
Who, how long, and what addiction? _____

Is there any mental illness currently or historically in you or your immediate/extended family members?
Who, and what mental illness?_____

Have you ever experienced or witnessed physical, emotional, sexual abuse, or a violent crime? If yes, please explain:_____

Previous participation in counseling? Y/N__ When _____ With Whom _____
What was the focus of your treatment? _____

Have you **ever** taken medication for a mental/emotional condition? Y/N__ If yes, complete the following:

Medication Name	Prescribed For	When Prescribed	How Long

Please list **all** other medications you are taking **currently** and what they are for._____

Previous hospitalization for mental/emotional problems? Y/N____ When_____ How long _____
Have you ever thought about killing yourself or attempted suicide? Y/N____If yes when_____
Please explain:_____

Describe any other significant or traumatic life experience. _____

If you have ever been diagnosed with a serious illness, please describe. _____

If you have any medical conditions that may affect your mental health treatment, please describe. _____

If you are experiencing any medical/physical symptoms that you attribute to a mental/emotional/stress related condition, please describe. _____

Describe your overall health today._____
Physical activity you participate in. _____

Symptoms or Concerns

Check all that apply:

- ☐ Feeling out of control
- ☐ Self-hatred
- ☐ Suicide attempts
- ☐ Hopeless
- ☐ Tearfulness
- ☐ Indecision
- ☐ Weight change
- ☐ Anxiety/nervousness
- ☐ Obsessive thoughts
- ☐ Stealing
- ☐ Impulsiveness
- ☐ Feelings of isolation
- ☐ Procrastination
- ☐ Grief
- ☐ Physical problems
- ☐ Hallucinations
- ☐ Hearing voices
- ☐ Recent loss
- ☐ Legal problems
- ☐ Menopause problems
- ☐ Learning problems
- ☐ Thoughts of dying
- ☐ Poor concentration
- ☐ Thoughts about suicide
- ☐ Agitation
- ☐ Mood changes
- ☐ Fatigue/tiredness
- ☐ Overwhelmed
- ☐ Angry outbursts
- ☐ Panic Attacks
- ☐ Hostility/rages
- ☐ Gambling
- ☐ Pornography
- ☐ Shyness
- ☐ Insecurity
- ☐ Sexual Problems
- ☐ Disruptive/conduct
- ☐ Dissociative episodes
- ☐ Bothersome memories
- ☐ Interpersonal conflicts
- ☐ Work problems
- ☐ School problem
- ☐ Lack of Motivation
- ☐ Guilt
- ☐ Slowed down
- ☐ Isolation/withdrawal
- ☐ Thoughts about hurting myself
- ☐ Fearful
- ☐ Sadness
- ☐ Emptiness
- ☐ Insomnia/oversleeping
- ☐ Overeating/Loss of appetite
- ☐ Irritability
- ☐ Loss of control
- ☐ Alcohol/drug addiction
- ☐ Sexual addiction
- ☐ Feelings of inferiority
- ☐ Feelings of failure
- ☐ Money problems
- ☐ Inappropriate speech
- ☐ Someone is trying to hurt me
- ☐ Recent crisis
- ☐ Domestic violence
- ☐ Family problems
- ☐ Social problems
- ☐ Worthlessness
- ☐ Restless/Keyed up

Any other important symptoms or concerns for your therapist to know:_____
_____
_____
_____

Therapist Notes:_____
_____
_____
_____
_____
_____
_____