Name: _____

FREMONT COUNSELING SERVICE
Intake Form

Name: _____ Age: _____ Date: _____

All responses to these questions are kept strictly confidential.

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem that brought you here today: _____

Please check all of the behaviors and symptoms that you consider to be problematic for you:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harming behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/school
- ☐ Recreational Activities
- ☐ Self-esteem
- ☐ Housing
- ☐ Health
- ☐ Relationships
- ☐ Legal matters
- ☐ Sexual Activities
- ☐ Hygiene
- ☐ Finances

Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No

If yes, please describe: _____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

	Maternal (Mother's Side)	WHO?	Paternal (Father's Side)
Family Mental Health Problems	☐		☐
Hyperactivity	☐		☐
Sexually Abused	☐		☐
Depression	☐		☐
Bipolar Disorder (Manic Depression)	☐		☐
Suicide	☐		☐
Anxiety	☐		☐
Panic Attacks	☐		☐
Obsessive-Compulsive	☐		☐
Anger/Abusive	☐		☐
Schizophrenia	☐		☐
Eating Disorder	☐		☐
Alcohol Abuse	☐		☐
Drug Abuse	☐		☐
OTHER:	☐		☐
OTHER:	☐		☐
OTHER:	☐		☐

Are your parents:
☐Legally married or living together?
☐Temporarily separated?
☐Divorced or permanently separated?

Mother remarried: _____ number of times
Father remarried: _____ number of times

What is the quality of your relationship with your:

Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Brothers/Sisters	☐Good	☐Poor	☐No Relationship	☐Other:_____
Spouse/Partner	☐Good	☐Poor	☐No Relationship	☐Other:_____
Children	☐Good	☐Poor	☐No Relationship	☐Other:_____

Please note if you have experienced or witnessed any of the following types of trauma or loss:

☐Emotional abuse	☐Neglect	☐Lived in a foster home
☐Terrorism	☐Combat Veteran	☐Natural disaster
☐Sexual abuse/assault	☐Violence in the home	☐Multiple family moves
☐Physical abuse/assault	☐Crime victim	☐Homelessness
☐Parent substance abuse	☐Significant parent illness	☐Loss of a loved one
☐Teen/unplanned pregnancy	☐Place a child for adoption	☐Financial problems

Name: _____

PREVIOUS MENTAL HEALTH TREATMENT

Have you had any previous mental health or substance use treatment?

YES	When?	Where?	Reason for Treatment?
☐ Outpatient counseling			
☐ Medication			
☐ Psychiatric hospitalization			
☐ Drug/alcohol treatment			
☐ Self-help/support groups			

SUBSTANCE USE HISTORY

Do you CURRENTLY use:

YES	How often?	How much?	Age of first use?
☐ Tobacco			
☐ Caffeine			
☐ Alcohol			
☐ Marijuana			
☐ Cocaine/crack			
☐ Ecstasy			
☐ Heroin			
☐ Inhalants			
☐ Methamphetamine			
☐ Prescription Pain Killers			
☐ PCP/LSD			
☐ Steroids / Tranquilizers			
☐ OTHER:			

Have you EVER used:	How often?	How much?	Age of first use?
☐ Tobacco			
☐ Caffeine			
☐ Alcohol			
☐ Marijuana			
☐ Cocaine/crack			
☐ Ecstasy			
☐ Heroin			
☐ Inhalants			
☐ Methamphetamine			
☐ Prescription Pain Killers			
☐ PCP/LSD			
☐ Steroids / Tranquilizers			
☐ OTHER:			

Have you ever had withdrawal symptoms when trying to stop taking any substances? ☐Yes ☐No
If yes, please describe: _____

Have you ever had problems with work, relationships, the law, etc. due to substance use? ☐Yes ☐No
If yes, please describe: _____

Name: _____

LEGAL INFORMATION

Have you ever been convicted of a misdemeanor or felony? ☐Yes ☐No

If yes, please describe: _____

Are you currently involved in any divorce and/or child custody proceedings? ☐Yes ☐No

If yes, please describe: _____

GAMBLING HISTORY

During the past 12 months:

- Have you become restless, irritable, or anxious when trying to stop/cut down on gambling? ☐Yes ☐No
- Have you tried to keep your family or friends from knowing how much you gamble? ☐Yes ☐No
- Did your gambling result in financial trouble that you had to get help with living expenses from family, friends or welfare? ☐Yes ☐No

INTERPERSONAL / SOCIAL / CULTURAL INFORMATION

Who would you include in your social support network?

☐Family ☐Neighbors ☐Friends ☐Students
☐Co-workers ☐Community group ☐Support/Self-help group
☐Religious/spiritual center (which one)? _____

How important are spiritual matters to you? ☐Very ☐Somewhat ☐Not at all

Do you live by yourself or with others? With who? _____

How long have you been in your current living situation? _____

Do you identify with a particular ethnic or cultural group? Which one(s)? _____

_____

Are ethnic or cultural issues causing difficulty in your life? Please describe: _____

_____

What gender do you identify with: ☐Male ☐Female ☐Neither ☐Other: _____

What is your sexual orientation: ☐Straight ☐Gay/Lesbian ☐Bi-sexual ☐Other: _____

MISCELLANEOUS INFORMATION

Are you currently employed? ☐Yes ☐No

Employer: _____ Position: _____

Length of time in position: _____ Level of Stress in this position: Low Medium High

Other jobs you have held: _____

Please list any sources of financial benefits or assistance you receive: _____

_____

Are you currently attending school? ☐Yes ☐No Last Grade / Year of School Completed: _____

Do you need assistance with reading or writing or have any special learning needs? ☐Yes ☐No

Have you been or are you currently in the military? ☐Yes ☐No Were you in combat? ☐Yes ☐No

Branch: _____ Rank: _____ Date / Type of Discharge: _____

Name: _____

MEDICAL HISTORY

_____

Date of last exam/treatment by a physician Reason for last exam/treatment

During the last four (4) weeks, how much have you been bothered by any of the following problems?

	Not Bothered	Bothered a Little	Bothered a Lot
Stomach pain	☐	☐	☐
Back pain	☐	☐	☐
Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
Menstrual cramps or other problems with your periods	☐	☐	☐
Pain or problems during sexual intercourse	☐	☐	☐
Headaches	☐	☐	☐
Chest pain	☐	☐	☐
Dizziness	☐	☐	☐
Fainting spells	☐	☐	☐
Feeling your heart pound or race	☐	☐	☐
Shortness of breath	☐	☐	☐
Constipation, loose bowels, or diarrhea	☐	☐	☐
Nausea, gas, or indigestion	☐	☐	☐
OFFICE USE: TOTAL SCORE =	**0**	**1 =**	**2 =**

_____ _____

Physician (Name/Location) Psychiatrist (Name/Location)

_____ _____

Eye Doctor (Name/Location) Dentist (Name/Location)

_____ _____

Pharmacy

Drug Allergies: _____

Are you currently pregnant and/or receiving prenatal care? ☐Yes ☐No ☐NA
Do you have any psychiatric Advance Directives? ☐Yes ☐No (If yes, was a copy provided?)
Would you like more information on psychiatric Advance Directives? ☐Yes ☐No

MEDICATION INFORMATION

Please include prescription medications as well as over-the-counter (OTC) medications, herbal supplements, vitamins, etc. If you need more space for more medications, please let reception know.

Medication Name	How much and How often?	Do they help? Any side effects/bad reactions?	Prescriber

Name: _____

TREATMENT CONSIDERATIONS

Please describe any special areas of interest, hobbies that you have, or other things that you enjoy doing:

_____

_____

Please describe your strengths, skills, talents, etc.: _____

_____

_____

Do you have any preferences for the treatment/services that you receive? (For example: Male or female clinician? How often would you like to be seen? Day/afternoon/evening appointments?)

_____

_____

_____

_____

Do you have a Wellness Recovery Action Plan (WRAP)? ☐Yes ☐No (If yes, was a copy provided?)
Would you like more information on WRAP? ☐Yes ☐No

What is your goal for treatment? What do you hope to accomplish by receiving services from us?

_____

_____

_____

_____

_____
Signature Date

==========

FOR OFFICE USE ONLY:

_____

_____

_____

_____

_____

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_____

_____

_____

_____
Intake Clinician Signature Date

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SCANNED: _____ ATTACHED TO FILE: _____
Date / By Date / By