HOPE ALIVE ~ INTAKE FORM

This form is intended to help your counselor become better acquainted with you and, in turn, serve you better. ***Please print*** *the information requested or checkmark the appropriate responses. You may omit any item but try to be as thorough as possible. Thank you.*

Name ______________________________________ Today's Date: ______________________

Birthdate ___________________________ Age: ________ Marital Status: S / M / D / W

Address ______________________________ City __________________ Zip ______________

Phone _______________________ Messages: Okay voicemail ___ Ok other person ___ no messages ___

Referred By:____

Emergency Contact Information

Name __________________________________ Relationship ___________________________

Address ______________________________ City __________________ Zip ______________

Phone _______________________ Messages: Okay voicemail ___ Ok other person ___ no messages ___

List Others Living in the Home, and all children

Name	Relationship	Age

Presenting Problem

Briefly describe why you are seeking counseling: ____________________________________

____

____

____

How would you rate the intensity of the problem or concern that let you to seek counseling?

(please circle) Extremely Intense Moderately Intense Not Intense

5 4 3 2 1

Approximately how long have you had this current problem or concern? ___________________

In what ways have you attempted to cope with this problem or concern? ___________________

____

What are your goals for therapy: ____

____

____

____

Cultural Background

What is your race/ethnicity?

___ White
___ Asian American
___ Black/African American
___ Native Hawaiian/Pacific Islander
___ Hispanic/Latino
___ American Indian/Alaskan Native
___ Multiracial (please specify)__________________
___ International (please specify) _________________

How much do you identify with your ethnic heritage __not at all__a little__somewhat __strongly

Does your family speak a language other than English at home? If yes, please specify: ________

Family Background

Please describe your relationships with your family:

Spouse/Intimate Partner:____

____

Father: ____

____

Mother: ____

____

Siblings: ____

____

Please check any past, present, or impending problems/issues in your family:

___ Death(s)
___ Financial crisis/unemployment
___ Debilitating injuries/disabilities
___ Eating Disorders
___ Martial affairs/infidelity
___ physical/sexual abuse
___ frequent relocations
___ attempted/completed suicide
___ serious/chronic illness
___ divorce
___ legal problems
___ alcohol/drug use
___ mental illness
___ other: _____________________

Please list those individuals (name/relationship) who are a source of emotional support to you:

____

Socio-Economic Information

Living Situation:
___ adequate housing ___ inadequate housing

Financial Situation:
___ finances are a major stressor
___ finances are not a major stressor for me

Legal History:
___ no legal problems
___ current legal issues
Please specify: ____________________________
___ legal problems in the past
Please specify: ____________________________

Please indicate your educational level:

___ Less than high school ___ Some College (no degree completed)
___ H.S. equivalent/GED ___ Bachelor's Degree
___ High School Diploma ___ Master's Degree
___ Vocational ___ Doctoral Degree ___ Other

Occupational Information

Are you currently employed? ___ no ___ yes

If yes, who is your currently employer/position? ____

Please list any work-related stressors, if any ____

____

Religious/Spiritual Information

Do you consider yourself to be religious? ___ yes ___ no

If no, do you consider yourself to be spiritual? ___ yes ___ no

If yes, what are your faith/spiritual beliefs and how do they impact your daily life? ___________

____

Have you ever been wounded by someone related to religious issues? ___ yes ___ no

Church Affiliation: ____

Primary Care Physician and Health History

Name ___________________________________ Phone ____________________________

Address _______________________________ City __________________ Zip _____________

How would you rate your overall health at present? ___ poor ___ fair ___ good ___ excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): ____

____

Please list any medications you are currently taking, the dosage, and the condition they treat:

____

____

Please list any previous hospitalizations, including date and reason: ________________________

____

____

How would you describe your sleep habits?

___ problems falling asleep ___ problems staying asleep ___ sleeping too much ___ disturbing dreams
___no sleep concerns ___ other:____________

How would you describe your appetite or eating habits?

__ decreased appetite ___ increased appetite ___ binge eating ___ restricting calories
___significant weight change (in the past 2 months) ___ other: _____________

Do you currently drink alcohol? ___ yes ___ no

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

____

How often do you currently engage in recreational drug use?

___ daily ___ weekly ___ monthly ___ rarely ___ never

Do you smoke cigarettes/e-cigarettes or use other tobacco products? ___ yes ___ no

If yes, how much to you smoke? ____

If your alcohol, drug, or tobacco consumption was different in the past compared to now, please describe your past use (when, how much, how often). ___________________________________

____

Mental Health History

Have you had previous counseling? ___no ___ yes, Please describe previous experience (How long ago? Was it positive or negative? What was helpful/unhelpful? Etc.) : _________________

____

____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with mental health? ___ no ___ yes If yes, please describe: ___________________

____

Have you had suicidal or homicidal thoughts recently?

___ frequently ___sometimes ___rarely ___never

Have you had them in the past?

___ frequently ___sometimes ___rarely ___never

Assets and Strengths

What are your special interests and hobbies? ____

____

____

What do you see as your personal strengths? ____

____

____

What values are important to you? ____

____

FOR OFFICE USE

Client is a: ___ Resident ___ Non-resident

Counselor's Name: ____

Clinical focus/impressions: ____

____

____

Fee Amount Agreed Upon: ____________________________________