COMPREHENSIVE CONFIDENTIAL INTAKE

IF THERE IS INSUFFICIENT SPACE, PLEASE FEEL FREE TO USE THE BACK SIDE OF THE FORM OR ADD MORE PAGES AS NEEDED.

Name:_____ Date: _____

Address:_____ Birthdate: _____

City/State/Zip:_____ Home Phone: _____

Email: _____ Work Phone: _____

How were you referred to me: _____ Cell Phone: _____

Profession: _____ Pronouns: _____

Sexual Orientation: ☐ Heterosexual ☐ Homosexual/Lesbian ☐ Pan/Bisexual ☐ Other: _____

Gender Identity: ☐ Male (Cis) ☐ Female (Cis) ☐ Transgender ☐ Transsexual ☐ Pangender/Androg

☐ Intersex ☐ NonBinary ☐ Gender Queer ☐ Gender Questioning ☐ Other: _____

☐ Single ☐ Divorced ☐ Widowed ☐ Married/Partnered ☐ Boyfriend/Girlfriend ☐ Other: _____

Name of significant other(s) _____

Do you live together? Y / N If yes, how long? _____

Who (else) do you live with? _____

Please list the names of your parents (include stepparents), siblings, and yourself in order of age. _____

_____

_____

_____

If you have children please list their name, age and gender along with any other information about them you think it might be helpful for me to know (e.g. living arrangements, disabilities, etc)

_____

_____

_____

What are your main reasons for coming to counseling/coaching? _____

_____

_____

_____

CLIENT NAME: _____

Condition Checklist: Physical issues can directly impact psychological functioning and vice versa. Please check the conditions that apply to you now or in the past and add your comments below.

Musculo-Skeletal
- ❑ Headaches
- ❑ Muscle tension
- ❑ Joint stiffness/swelling/pain
- ❑ Spasms/cramps
- ❑ Broken/fractured bones
- ❑ Strains/sprains
- ❑ Back/hip pain
- ❑ Shoulder/neck pain
- ❑ Arm/hand pain
- ❑ Leg/foot pain
- ❑ Chest/ribs/abdominal pain
- ❑ Jaw pain/TMJ
- ❑ Tendonitis / Bursitis
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Bone/joint disease
- ❑ Other_____

Skin
- ❑ Rashes
- ❑ Allergies
- ❑ Eczema
- ❑ Athlete's foot
- ❑ Acne
- ❑ Other_____

Sexual
- ❑ Gender dysphoria
- ❑ Erectile dysfunction
- ❑ Premature ejaculation
- ❑ Painful intercourse
- ❑ Sexual aversion/lack of desire
- ❑ Other _____

Reproductive System
- ❑ Pregnancy
  - ☐ Current ☐ Previous
- ❑ Abortion
- ❑ PMS/PMDD
- ❑ Menopause
- ❑ Endometriosis/Fibroids
- ❑ Other_____

Digestive/Urinary
- ❑ Indigestion
- ❑ Constipation - Chronic
- ❑ Intestinal gas/bloating
- ❑ Diarrhea - Chronic
- ❑ Diverticulitis or Colitis
- ❑ Irritable bowel syndrome
- ❑ Crohn's disease
- ❑ Interstitial cystitis
- ❑ Other: _____

Circulatory and Respiratory
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Cold feet or hands
- ❑ Cold sweats
- ❑ Swollen ankles
- ❑ Varicose veins / Blood clots
- ❑ Stroke
- ❑ Heart condition
- ❑ Allergies
- ❑ Sinus problems
- ❑ Asthma
- ❑ Low or High blood pressure
- ❑ Lymphedema
- ❑ Other_____

Nervous System
- ❑ Numbness/tingling
- ❑ Fatigue
- ❑ Chronic pain
- ❑ Sleep disorders
- ❑ Ulcers
- ❑ Paralysis
- ❑ Herpes/shingles
- ❑ Cerebral palsy
- ❑ Epilepsy
- ❑ Chronic fatigue syndrome
- ❑ Multiple sclerosis
- ❑ Muscular dystrophy
- ❑ Parkinson's disease
- ❑ Spinal cord injury
- ❑ Other_____

Other
- ❑ Surgeries
- ❑ Fibromyalgia
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Multiple Sclerosis
- ❑ Pernicious Anemia
- ❑ Sickle Cell Anemia
- ❑ Cancer
- ❑ Hypothyroid
- ❑ Hyperthyroid
- ❑ HIV/AIDS/Infectious Condition
- ❑ Visually impaired
- ❑ Hearing impaired
- ❑ Other _____

Comments for any check boxes on previous page:_____

_____

_____

_____

Please describe any self-care practices (include exercise): _____

_____

_____

How would you describe your racial/ethnic/cultural background? _____

How would you define your faith system/religion and what spiritual practices do you engage in? _____

How would you describe your relationship with your body? _____

How do you express your sexuality/get your sexual needs met? _____

On average, how many hours per night do you sleep? _____

How would you describe your eating habits? _____

Sugar Intake: _____ Processed Food? _____ Caffeine: _____

Medications:

Current non-prescription medications, supplements & vitamins _____

Current prescription medications (include doses)_____

Previous/Discontinued prescription medications (include doses)_____

Other Medical:

Current Physicians	**Type of Care**
	Primary Health Care Provider

When was the last time you had a full physical evaluation? _____

Did you have a blood panel done at that time? ☐ Yes ☐ No

If so, what were the results? _____

Other medical history that hasn't been noted: _____

_____

_____

Symptom Checklist: Please check any of the following symptoms that apply to you:

	Now	During Past Year		Now	During Past Year
Feel sad			Explosive Temper		
Loss of interest			Mood swings		
Feel hopeless			Feel on edge		
Nothing is fun			Worry too much		
Loss of appetite			Impatient		
Weight loss			Panicky		
Weight gain			Dry mouth		
No energy			Bowel problems		
Cry easily			Hyperventilation		
Can't concentrate			Faintness/dizziness		
Forgetfulness			Pounding heart		
Can't fall asleep			Perseverating thoughts		
Sleep too much			Trembling		
Guilt feelings			Sweating		
Restlessness			Chocking sensations		
Irritable mood			Nausea		
Think of suicide			Chest pain		
No desire to live			Undifferentiated fear		
Waking up early			Anxiety or fear of:		
Feel worse in the AM			Crowds		
No need for sleep			Busses		
Talking too much			Stores		
Racing thoughts			Heights		
Buying sprees			Talking in public		
Reckless driving			Going crazy		
Sexually overactive			Dying		
Uncontrollable urges			Other		

Say more about anything you've checked: _____

_____

_____

_____

_____

Chemical Dependency / Abuse History

1. Have you ever tried to cut down your drinking / drug use / gambling? Y / N
2. Have you ever thought that you had a problem with alcohol, drugs, or gambling? Y / N
3. Have you ever had negative consequences after drinking, using or gambling? Y / N
4. Has anyone ever suggested you have a problem with alcohol, drugs or gambling? Y / N
5. Have you ever used more than you intended to use or spent more than you intended? Y / N

IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE COMPLETE THIS SECTION. IF NOT, SKIP TO MEDICATION SECTION.

Drug	Age of First Use	Last Use	Amount of Use	Frequency of Use	Route of Administration	Consider it a problem?
Alcohol						
Marijuana						
Cocaine						
Heroin						
Prescription Drugs						
Other						

Previous Treatment for Substance Abuse

Date	Who / Where	Type of Program	Outcome/Sobriety

Longest Period of Sobriety: _____ Longest Period of gambling absence: _____

Have you ever harmed yourself while under the influence? Y / N

Have you ever harmed anyone else while under the influence? Y / N

Age first gambled? _____ Most you've ever lost gambling? _____

How much technology/social media do you engage in per day or week? E.g. gaming, social media, etc: _____

Mental Health History: Have you been diagnosed with any mental condition or biochemical imbalance?

What is your history of physical, sexual, verbal or emotional abuse? _____

Are you a survivor of any other trauma that has not been named? _____

Have you ever attempted suicide? If so, please provide more info (e.g. number of attempts, age, circumstances)

History of Mental Health Treatment – Inpatient

Date	Hospital	Reason for Admission	Length of Stay

Total number of psychiatric hospitalizations: _____

History of Mental Health Treatment – Outpatient

Date	Who / Where	Reason for Seeking Services	Outcome or Benefit

Current Therapist/Healers **Type of Care**

Is there any other information that you think might be helpful in order to understand you and your needs better?

I certify that the responses are correct to the best of my knowledge. I agree to inform my provider should my physical or mental condition change.

Client Signature Date

Parent/Guardian Signature Date