Client Intake Form

Rose Counseling

600 Twelve Oaks Center Drive, #642A
Wayzata, MN 55391
612.386.4864

Client Name_____ Date of Intake_____

Complete Address_____

Home Phone_____ Work Phone_____ Cell _____

Date of Birth_____ Email Address_____

Name of Employer or School_____

Spouse or Parent/Guardian:

Name_____ Work Phone_____ # of yrs. Married _____

Place of Employment_____ Date of Birth_____

Family Members (if children, please give ages) and/or significant others_____

_____

_____

_____

Current Service Providers_____
_____

Please provide the following information about yourself or your child if you are a parent or guardian. This information will help me better understand the problems you are having. The information is confidential and will not be released to anyone without your permission.

Problems that you are having:

___ Depression
___ Suicidal thoughts
___ Suicidal actions
___ Anxiety/Fears/Worries
___ Panic attacks
___ Anger/Temper problems
___ Alcohol/other drug abuse (self)
___ Alcohol/other drug abuse (family)
___ Job/School problems
___ Financial concerns
___ Legal problems
___ Parent-child conflict (self)
___ Parent-child conflict (spouse)
___ Marital/relationship problems
___ Remarried family problems
___ Violence in the family
___ Communication problems
___ Verbal/Emotional abuse
___ Sexual problems
___ Sexual abuse (past or current)
___ Low self-esteem
___ Compulsive gambling

___ Death of a loved one
___ Major losses/difficult changes
___ Change in appetite
___ Difficulties in concentrating
___ Fatigue/low energy
___ Hyper/too much energy
___ Loss of interest in things
___ Repeated actions I can't stop
___ Eating disorder
___ Sleep problems
___ Moody or crying more than usual
___ Feeling guilty, worthless, or hopeless
___ Problems remembering things
___ Withdrawing from others
___ Disturbing thoughts I can't stop
___ People are out to get me

Others (please specify):_____

Medical History

Primary Physician:_____ Date of last Physical:_____
Clinic Name and Location:_____
Please list any chronic or serious illnesses:_____
_____

List any previous suicide attempts:_____
_____

Current prescriptions/medications:_____
_____

Any previous medications used for emotional problems and whether or not they were helpful:_____

Over the counter medicines used frequently:_____

Mental Health History

Please list previous therapy, hospitalizations, and/or evaluations:

When	Where	By Whom

Have any blood relatives experienced significant mental health problems? If so, explain.
_____
_____

Abuse History

Have you ever been abused?

Physically	___ Yes	___ No	___ Not sure
Emotionally	___ Yes	___ No	___ Not sure
Sexually	___ Yes	___ No	___ Not sure

Comments:_____
_____
Was abuse a problem in your family when growing up?_____
Is it currently a problem?_____

Family of Origin

Mother's name: _____
Father's name: _____
Mother's age: _____
Father's age: _____
Mother's location: _____
Father's location: _____
Mother's health: _____
Father's health: _____
Mother's profession: _____
Father's profession: _____

Write 3 adjectives to describe your Mother:

(1) _____
(2) _____
(3) _____

Write 3 adjectives to describe your Father:

(1) _____
(2) _____
(3) _____

Siblings and ages: _____

Lifestyle Choices

Have you or others ever thought your use of alcohol or drugs was a problem?
Alcohol ___ Yes ___ No
Smoking ___ Yes ___ No
Other drugs ___ Yes ___ No
Amount/type of alcohol per week: _____
Amount/type of other drug use per week: _____
Amount of tobacco use per day: _____
Amount/type of caffeine use per day: _____
History of chemical dependency treatments? _____
If yes, when and where?
_____
_____
Do you attend AA or other similar groups? _____
Are there any guns or weapons in the house?_____
Any legal charges (if so, please specify)? _____
_____

Sources of Stress

Please list the things/events/problems that are creating stress in your life at the present time (including significant losses and changes in your life):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current Functioning

Please list a number on a scale of one to ten with one indicating you are coping with things the worst you ever have in your life and ten indicating you are coping with things the best you ever have in your life: _____

List the people in your life that are the most supportive and/or helpful to you at this time:

_____

_____

What do you consider to be your major strengths: _____

_____

Goals in Counseling

Please list the goals you hope to achieve in counseling. Please be as specific as you can.

1. _____
2. _____
3. _____
4. _____