

Client Intake Form
Rose Counseling

14451 Hwy. 7, Suite #2A
Minnetonka, MN 55345
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:

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

- | | |
|---|---|
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Major losses/difficult changes | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Moody or crying more than usual |
| <input type="checkbox"/> Difficulties in concentrating | <input type="checkbox"/> Feeling guilty, worthless, or hopeless |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Problems remembering things |
| <input type="checkbox"/> Hyper/too much energy | <input type="checkbox"/> Withdrawing from others |
| <input type="checkbox"/> Loss of interest in things | <input type="checkbox"/> Disturbing thoughts I can't stop |
| <input type="checkbox"/> Repeated actions I can't stop | <input type="checkbox"/> 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:

<u>When</u>	<u>Where</u>	<u>By Whom</u>
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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. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 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. _____