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 **COLLABORATIVE COUNSELING GROUP**

 **Intake Form**

**GENERAL INFORMATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Never \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_Divorced \_\_\_\_ Widowed \_\_\_\_\_\_\_\_

List any children and age (s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_

Please circle which number you wish to be reached.

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***PLEASE NOTE THAT EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNCATION.**

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Circle: Full-time Part-time Self employed Unemployed

Racial/Ethnic Identity: African-America \_\_\_\_\_ Asian-American \_\_\_\_\_ White \_\_\_\_ Hispanic \_\_\_\_

Native-American\_\_\_\_\_ Other \_\_\_\_\_

Do you attend a church? Y N If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COUNSELING BACKGROUND**

Have you received any type of mental health services (psychotherapy, psychiatric services, etc.) in the past? Y N

If YES, when and by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what purpose and length of treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

Name and phone number of current physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any **prescription medication**? Y N

Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle your **current health**: Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Please circle your current **sleeping habits**: Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

List any difficulties with your **appetite or eating patterns**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink **alcohol**? Y N How much a day? \_\_\_\_\_\_ Week? \_\_\_\_\_\_\_\_

Do you currently partake in **recreational drugs**? Y N What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY**

**In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.)**

 Please Circle List Family Member

Alcohol/Substance Abuse Y / N

Anxiety Y / N

Depression Y / N

Domestic Violence Y / N

Eating Disorders Y / N

Obsessive Compulsive Behavior Y / N

Schizophrenia Y / N

Bipolar Y / N

Suicide Attempts Y / N

**REASON (S) FOR THERAPY**

Are any of the following conditions a problem for you at this time? (circle all that apply)

Anxiety Self esteem Loss of Meaning in life

Grief Stress Loss of Faith in God

Depression Substance abuse Conflicts at work

Irrational fears Chronic fear Religious doubts

Nervousness Guilt feelings Sleep issues

Loneliness Suicidal feelings Self-mutilation

Anger Loss of Hope Other- please list

Marriage problems Rage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual concerns Relationship with parents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of work/job Relationship with children

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Counselor signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**