|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | [http://www.mariacollege.edu/sites/default/files/logo.jpg](http://www.google.com/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0CAcQjRxqFQoTCImIg6fwo8gCFUsaPgodvDUIig&url=http://www.mariacollege.edu/&psig=AFQjCNFBDFfgiLQXR3k7KtFDsscRYFISQg&ust=1443878390308041) | Department of Student Affairs | | 518-861-2508 | | FAX 518-730-9628 | | Student Support Center, Mercy Hall | |  |

**Counseling Office Client Paper Intake Form**

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

**General Health Information**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List any present symptoms (mental health, physical or emotional) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you currently have a primary care physician? 🞎 Yes 🞎 No

If yes, who is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medication that you are presently taking (including vitamins and homeopathic).

|  |  |  |  |
| --- | --- | --- | --- |
| **Prescription name** | **Dosage**  **(Daily, Weekly, etc.)** | **Prescriber**  **(Medical Provider)** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Treatment History**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

🞎 Yes 🞎 No

Name and contact information of provider

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous psychotherapy?

🞎 Yes 🞎 No

Please provide previous therapist’s name and contact information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral and Social Information**

Do you feel you have a strong support system? (list those who you feel supported by)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last year, have you experienced any significant life changes or stressors? If yes, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any problems with your sleep habits? 🞎 Yes 🞎 No

If *yes*, check where applicable: 🞎 Sleeping too little 🞎 Sleeping too much 🞎 Poor quality sleep

🞎 Disturbing dreams 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times per week do you exercise?

🞎 Daily 🞎 Weekly 🞎 Monthly 🞎 Rarely 🞎 Never

Approximately how many minutes each time?

🞎 < 15 🞎 < 30 🞎 < 60 🞎 More than 60 minutes

Are you having any difficulty with appetite or eating habits? 🞎 Yes 🞎 No

If yes, check where applicable:

🞎 Eating less 🞎 Eating more 🞎 Bingeing 🞎 Restricting

Have you experienced significant weight change in the last 2 months? 🞎 Yes 🞎 No

Do you regularly use alcohol? 🞎 Yes 🞎 No

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

🞎 Daily 🞎 Weekly 🞎 Monthly 🞎 Rarely 🞎 Never

How often do you engage recreational drug use?

🞎 Daily 🞎 Weekly 🞎 Monthly 🞎 Rarely 🞎 Never

Do you smoke cigarettes or use other tobacco products? 🞎 Yes 🞎 No

Are you currently in a romantic relationship? 🞎 Yes 🞎 No

If yes, how long have you been in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (10 equals highly satisfied), how would you rate your current relationship? \_\_\_\_

Have you ever experienced any of the following?

|  |  |
| --- | --- |
| Extreme depressed mood | Yes / No |
| Dramatic mood swings | Yes / No |
| Rapid speech | Yes / No |
| Extreme anxiety | Yes / No |
| Panic attacks | Yes / No |
| Phobias | Yes / No |
| Sleep disturbances | Yes / No |
| Hallucinations | Yes / No |
| Unexplained losses of time | Yes / No |
| Unexplained memory lapses | Yes / No |
| Alcohol/substance abuse | Yes / No |
| Frequent body complaints | Yes / No |
| Eating disorder | Yes / No |
| Body image problems | Yes / No |
| Repetitive thoughts (e.g. obsessions) | Yes / No |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No |
| Homicidal thoughts | Yes / No |
| Suicidal Thoughts/ Attempts | Yes / No If yes, when?  Did you ever have a plan? |

**Occupational Information**

Are you currently employed? 🞎 Yes 🞎 No

If yes, who is your currently employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you happy with your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any work-related stressors, if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious/Spiritual Information**

Do you consider yourself to be Spiritual? 🞎 Yes 🞎 No

If yes, what is are your customs or practices? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Mental Health History**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Yes / No** | **Family member** |
| Depression | Yes / No |  |
| Bipolar disorder | Yes / No |  |
| Anxiety disorder | Yes / No |  |
| Panic attacks | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Alcohol/substance abuse | Yes / No |  |
| Eating disorders | Yes / No |  |
| Learning disabilities | Yes / No |  |
| Trauma history | Yes / No |  |
| Suicide attempts | Yes / No |  |
| Death by Suicide | Yes / No |  |
| Chronic illness | Yes / No |  |
| Other | Yes / No |  |

**Other Information**

What do you consider to be your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you like most about yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are effective coping strategies that you have learned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date