

Future Hope Counseling

Client Intake

Name: _____ Date: _____
(First) (Middle Initial) (Last)
Address: _____ Phone: _____ (Home) _____ (Wk/Cell)

E-mail address:

May we contact you by e-mail? Yes No
May we leave a phone message? Yes No

Date of Birth: _____ Gender: Male Female

Ethnicity:

Who referred you to our counseling center?

Current Marital Status:

Single Engaged Married Separated Divorced Widowed

If married, give spouse's name:

Previous Marital Status:

Have you been previously married? _____ How many times?
If married, has your spouse been previously married? _____ How many times?

Dates of your previous marriage(s) and divorce(s):

If married, dates of your spouse's previous marriage(s) and divorce(s):

Briefly describe why the previous marriage(s) ended:

Yourself:

Your Spouse:

Children from Current Marriage:

Name	Age	Sex
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Children from Previous Marriage(s):

Name	Age	Sex
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Other Children in the Home

Name	Age	Sex
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Religious Affiliation:

Jewish Catholic Protestant None, but believe in God Atheist/Agnostic
Other _____

Do you wish to have your religious beliefs and values incorporated into the counseling process?

Yes No Not sure

Counseling History:

Have you or a family member previously been in counseling, psychotherapy, psychiatric treatment or had a psychological assessment? (Please mark ‘Y’ or ‘N’)

- Self: Yes No
- Spouse: Yes No
- Child: Yes No
- Father: Yes No
- Mother: Yes No
- Other member: Yes No

If “Yes” please answer the following:

Date(s) counseling or other treatment started: _____ ended: _____
 Individual/hospital providing treatment: _____
 Purpose of therapy: _____

How was it helpful?

How was it not helpful?

Please answer the following by marking ‘Y’ for yes or ‘N’ for no:

- Do you currently use alcohol or other non-prescription drugs? Yes No
- Is there a history of mental health problems in your family? Yes No
- Have you ever been physically abused? Yes No
- Have you ever been emotionally abused? Yes No
- Have you ever attempted suicide? Yes No
- Is there a history of alcohol or drug problems in your family? Yes No
- Have you ever been in legal trouble? Yes No
- Have you ever been sexually abused or assaulted? Yes No
- Are you currently taking any prescription medications? Yes No
 If “yes” please list medicine and purpose for use _____
- Have you ever been hospitalized for mental health reasons? Yes No
 If “yes” please discuss _____

Current Counseling Concerns:

Briefly describe the concerns you would like to discuss with the counselor

How long has the problem persisted?

Briefly describe any medical conditions that you have

You may use the space below to include anything additional that you would like the counselor to know

Please mark all of the following that apply (past 12 mos.)

Feelings

- | | | | |
|-----------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Helpless | <input type="checkbox"/> Anxious | <input type="checkbox"/> Depressed | <input type="checkbox"/> Out of Control |
| <input type="checkbox"/> Shameful | <input type="checkbox"/> Afraid | <input type="checkbox"/> Angry | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Guilty | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Excited | <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeful |
| <input type="checkbox"/> Stressed | <input type="checkbox"/> Feeling inferior | <input type="checkbox"/> Unhappy | <input type="checkbox"/> Mood shifts |
| <input type="checkbox"/> Other | | | |

Thoughts

- | | | | |
|---------------------------------------|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Confused | <input type="checkbox"/> Racing | <input type="checkbox"/> Unintelligent | <input type="checkbox"/> Obsessive |
| <input type="checkbox"/> Worthless | <input type="checkbox"/> Distracted | <input type="checkbox"/> Unmotivated | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Unattractive | <input type="checkbox"/> Paranoid | <input type="checkbox"/> Unlovable | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Honest | <input type="checkbox"/> Homicidal |

Symptoms/Behaviors for the last year

- | | | |
|--|---|--|
| <input type="checkbox"/> Eating Less | <input type="checkbox"/> Acting out sexually | <input type="checkbox"/> Socializing |
| <input type="checkbox"/> Procrastinating | <input type="checkbox"/> Acting aggressively | <input type="checkbox"/> Extra-marital relationships |
| <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> Disorganization | <input type="checkbox"/> Parent/child conflict |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Lack of ambition/goals |
| <input type="checkbox"/> Crying excessively | <input type="checkbox"/> Recklessness | <input type="checkbox"/> Poor peer relationships |
| <input type="checkbox"/> Withdrawing socially | <input type="checkbox"/> Irritability | <input type="checkbox"/> Night mares |
| <input type="checkbox"/> Skipping classes/work | <input type="checkbox"/> Passivity | <input type="checkbox"/> Worries about body image |
| <input type="checkbox"/> Binge drinking | <input type="checkbox"/> Drug use | <input type="checkbox"/> Spiritual problems |
| <input type="checkbox"/> Injuring self | <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Dating concerns |
| <input type="checkbox"/> Compulsivity | <input type="checkbox"/> Being good to yourself | <input type="checkbox"/> Financial trouble |
| <input type="checkbox"/> Change in career | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Death of friend/relative |
| <input type="checkbox"/> Other | | |

Physical Symptoms

- | | | |
|---|--|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tired | <input type="checkbox"/> Weight gain or loss |
| <input type="checkbox"/> Tightness in chest | <input type="checkbox"/> Dizzy or light headed | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Rapid heart rate | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Excessive sleep | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eating problems | |
| <input type="checkbox"/> Other | | |