Future Hope Counseling

Youth Client Intake

Name: Date:
(First) (Middle Initial) (Last)
Address: City/State/Zip

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?

Names of Parents or Guardian:
Mother's Name Occupation

Father's Name Occupation

Legal Guardian Occupation

Marital Status of Parent(s):
Single☐ Married☐ Separated☐ Divorced☐

How long

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: ☐ Spouse: ☐ Child: ☐ Father: ☐ Mother: ☐ Other member: ☐ (who)
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

☐Helpless	☐Anxious	☐Depressed	☐Out of Control
☐Shameful	☐Afraid	☐Angry	☐Numb
☐Guilty	☐Relaxed	☐Hopeless	☐Happy
☐Lonely	☐Excited	☐Sad	☐Hopeful
☐Stressed	☐Feeling inferior	☐Unhappy	☐Mood shifts
☐Other			

Thoughts

☐Confused	☐Racing	☐Unintelligent	☐Obsessive
☐Worthless	☐Distracted	☐Unmotivated	☐Disorganized
☐Unattractive	☐Paranoid	☐Unlovable	☐Suicidal
☐Confident	☐Sensitive	☐Honest	☐Homicidal

Symptoms/Behaviors for the last year

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

Physical Symptoms

☐Insomnia	☐Tired	☐Weight gain or loss
☐Tightness in chest	☐Dizzy or light headed	☐Numbness
☐Vomiting	☐Rapid heart rate	☐Dry mouth
☐Pain	☐Excessive sleep	☐Loss of memory
☐Headaches	☐Eating problems	
☐Other		