

Break Thru Counseling Center Intake Form

Name _____ Today's Date _____

Address _____ City _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Check for Yes – May we call you at: H _____ W _____ C _____ E-mail: _____

Check for Yes – May we identify ourselves: H _____ W _____ C _____

E-mail address: _____ Check if we can contact you by email: _____

Age _____ Birth Date _____ Place of Birth _____

Employer _____ Occupation _____

Educational Level _____ Referred By: _____ May we thank that person? _____

Emergency Contact _____

Name	Relationship	Phone Number
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Reason you are seeking counseling today _____

Marital Status (please check one, and fill in detail if applicable)

Single _____ **Living with Significant Other** _____ how long together _____

Engaged _____ wedding date _____ how long together _____

Married _____ years married _____ number of previous marriages _____

Separated _____ how long _____ **Divorced** _____ date _____

Widowed _____ how long _____

Name of spouse or significant other _____

Describe your relationship _____

Children (if more than 4 please list on back of page)

Name	Relationship	Age	Sex	Living at home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who has legal custody of your children? _____

Describe what it is like to live in your household today. _____

Describe your family and household when you were growing up. _____

Are there any current addictions or history of addictions in you or immediate/extended family members (drugs, alcohol, sex, gambling, eating, pornography, prescription drugs, work, or other)? _____
Who, how long, and what addiction? _____

Is there any mental illness currently or historically in you or your immediate/extended family members? _____
Who, and what mental illness? _____

Have you ever experienced or witnessed physical, emotional, sexual abuse, or a violent crime? If yes, please explain: _____

Previous participation in counseling-Y/N____ When _____ With Whom _____
What was the focus of your treatment? _____

Have you **ever** taken medication for a mental/emotional condition? Y/N____ If yes, complete the following:

Medication Name	Prescribed For	When Prescribed	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list **all** other medications you are taking **currently** and what they are for. _____

Previous hospitalization for mental/emotional problems-Y/N____ When____ How long _____
Have you ever thought about killing yourself or attempted suicide? Y/N____ If yes when _____
Please explain: _____

Describe any other significant or traumatic life experience. _____

If you have ever been diagnosed with a serious illness, please describe. _____

If you have any medical conditions that may affect your mental health treatment, please describe. _____

If you are experiencing any medical/physical symptoms that you attribute to a mental/emotional/stress related condition, please describe. _____

Describe your overall health today. _____
Physical activity you participate in. _____

Symptoms or Concerns

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Feeling out of control | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Isolation/withdrawal |
| <input type="checkbox"/> Self-hatred | <input type="checkbox"/> Thoughts about suicide | <input type="checkbox"/> Thoughts about hurting myself |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Agitation | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Tearfulness | <input type="checkbox"/> Fatigue/tiredness | <input type="checkbox"/> Emptiness |
| <input type="checkbox"/> Indecision | <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> Insomnia/oversleeping |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Angry outbursts | <input type="checkbox"/> Overeating/Loss of appetite |
| <input type="checkbox"/> Anxiety/nervousness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Hostility/rages | <input type="checkbox"/> Loss of control |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Gambling | <input type="checkbox"/> Alcohol/drug addiction |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Pornography | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Feelings of isolation | <input type="checkbox"/> Shyness | <input type="checkbox"/> Feelings of inferiority |
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Feelings of failure |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Money problems |
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Disruptive/conduct | <input type="checkbox"/> Inappropriate speech |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Dissociative episodes | <input type="checkbox"/> Someone is trying to hurt me |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Bothersome memories | <input type="checkbox"/> Recent crisis |
| <input type="checkbox"/> Recent loss | <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Work problems | <input type="checkbox"/> Family problems |
| <input type="checkbox"/> Menopause problems | <input type="checkbox"/> School problem | <input type="checkbox"/> Social problems |
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Worthlessness |
| <input type="checkbox"/> Thoughts of dying | <input type="checkbox"/> Guilt | <input type="checkbox"/> Restless/Keyed up |
| | <input type="checkbox"/> Slowed down | |

Any other important symptoms or concerns for your therapist to know: _____

Therapist Notes: _____
