Referral Source:

COMPREHENSIVE INTAKE FORM ***Chrissy Zimmerman Counseling***

503.502.8593

chrissy.zimmerman.lpc@gmail.com

Client's Name: ____________________________________Today's Date: ___________
Gender: *Male Female Other*:_______ Age: ___________Date of **Birth**: ______________
Name of person filling out this questionnaire: ______________________ Relation to Client: __________
Home Address: ____City/State/Zip:___________________
Cell Phone:__________________________ Okay to leave a confidential message? Yes/ No
(optional)Email address: _____________________________________Is your email confidential Yes/No
Emergency Contact ____(___)_____________
Name Relationship Phone
What **Culture** you most identify with____
How would you define your sexuality and/or sexual identity? _____________________________________
Describe your Spiritual Practice/ Religious Affiliation:____
What is your Educational Background?: ____
Are you currently employed?: ____ Looking? ___ Occupation: ___________________Do you like your job?__

Please briefly explain a number of things you look forward to addressing in therapy:

____
____
____

How long has this been going on? ____
____

To what degree does it affect your ability to function on a daily basis? 1 2 3 4 5 6 7 8 9 10
Explain … Hardly Intensely Severely
____

In what ways have you tried to manage these concerns in the past? (e.g., therapy, medications, respite, drugs/alcohol, family interventions, mediation, etc)?

____
____

Do you currently have a prescribing physician for psychiatric medication?

Name of Doctor/Clinic: ________________________________Contact Number: ______________________
Date of last appointment or contact with your doctor: _________ Do you see any **other** healthcare providers?

☐Chiropractor ☐ Naturopath ☐ Acupuncture ☐Bio-feedback ☐ Massage ☐Other:___________________

Do you have any allergies? If so, please list them. ____

List any Prescription Medications currently taking (include name, dosage, and frequency)

____
____

Please list any over the counter medication, vitamins, sleep aids, other supplements you use…

____

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Family Information

Describe your family in one or two (or more) words: ______________________ ______________________

Current Marital Status: Married Divorced Separated Single Other:______________________________
Spouse/ Partner's Name: ______________________________ Age:________ Education: ______________

Children (Include all ***b****iological,* ***a****dopted,* ***f****oster,* ***s****tep, or* ***g****rand-*):

Name	*Sex*	*Age*	***(b,a,f,s*** *or* ***g)***	*Custody &* *a* brief statement about your relationship	
				Y/N	
				Y/N	
				Y/N	
				Y/N	

Please identify and explain any current family/relationship/ environmental/ personal **stressors** that seem relevant to your difficulties.____
____
____

Biological **Mother**: ____________________________________ *Step-Father?* __________________
Describe your relationship with her: ____
Biological **Father**: ____________________________________ *Step-Mother?* __________________
Describe your relationship with him: ____
Who were your primary Caregiver(s) growing up? ____
List your siblings (if any), their ages, and briefly describe your relationships with them:
____
____
Where were you born and raised (include significant moves, changes and transitions)? ______________
____

Was your childhood impacted by alcohol or drugs, mental illness, criminal activity or violence?
___ Medical problems or concerns If yes, what/who? ____
___ Aggression, Oppositional Behavior If yes, who? ____
___ Attention, Hyperactivity, Impulsiveness If yes, who? ______________________________________
___ Psychosis, Schizophrenia If yes, who? ____
___ Mood Problems, Depression If yes, who? ____
___ Anxiety Problems, Excessive Worrying If yes, who? ______________________________________
___ Substance Abuse If yes, who/what? ____
___ Legal Problems If yes, who/what? ____
___ Suicide, Self-harm If yes, who/**when**? ____

Have you experienced significant losses in your life? If so, what or whom and when?
____

Did you experience **childhood** neglect, emotional abuse, physical abuse and/or sexual abuse? (circle)
Please share as many details as you feel comfortable giving at this time: ______________________________
____

Did you receive any support for above circled responses? If not, what happened? If so, from whom?
____

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Beyond childhood (as an **adult**), have you experienced any other violence or have you been harmed physically, *sexually* or emotionally? If so, please briefly explain. ________________________________

____

Please describe any support you received and from whom. ____

____

Describe FRIENDSHIPS, COMMUNITY, & SPIRITUALITY

____

____

____

Describe your current living situation? ____

How long? __________________________ **Any recent changes?** ____________________________________

Risk Factors and Brief Safety Assessment

Circle all that you are experiencing currently:

feeling worthless *feeling hopeless* *irritable* *trouble sleeping* *angry outbursts* *withdrawing from social/family situations*
isolation *using drugs and/or alcohol* *increased sexual encounters* *frequent thoughts of suicide or self-harm*

What are your biggest current stressors?____

History of self harm, cutting, or suicidal behavior? **Yes/No** Family history of suicide? **Yes/No**

Safety Plan… (*What you would do to feel safe if you started having increased suicidal thoughts*) ______________________________

____

Lifestyle/ Habits:

Estimate how many hours/day you spend online…

Facebook _____, YouTube ____, Twitter _____, internet gaming ____, research____ , working ____
browsing ____, porn _____, streaming TV/movies _____, and other: ________________

Habits	**Age when 1st began using…**	**Times per week**	**Current or Past**
Caffeine- soda/coffee			
Cigarettes, cigars, etc			
Rx Medications			

Substance Use/ Abuse History:

Have you ever used drugs or alcohol? Yes No

If yes please describe:

Substance (pot, coke, meth, shrooms, pills (oxy), inhalants, hallucinogens, etc…)	**Age when 1st began using or experimenting with…**	**Amount/Frequency** (e.g.: *one bowl/ 3x a day…*)	**Date of Last Use**

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What gives you the most joy or pleasure in your (*Client's*) life?

Please list some of your strengths and talents.

What are your primary worries or fears?

Are you satisfied with your Relationship and/or sex life?

What are your most important hopes and dreams?

How do you like to spend your free time?

If Ct is a child, please list any significant (positive or challenging) events and developmental milestones.
For example; was very colicky, age started walking/talking, fussy eater, separated from caregiver easily or not, was bit by dog, etc.

Therapy GOALS: Please summarize what you would like to see change as a result of coming to therapy at this time.

Thank you. And feel free to make any other comments, questions or to express further concerns here.