Courage to Connect Counseling, PLLC

Individual Intake Form

Please complete this form a fully as possible.

General Information

Today's Date: ______/_______/__________

Referred by: ☐internet ☐psychology today ☐good therapy ☐theravive ☐personal or other: ______________________

Name: ______________________________________ DOB: ____/_______/______ Age: ________________

First Last MI

Gender (as identified): ☐ Male ☐ Female

Race/Ethnicity: __________________________________

Is culture important to you: ☐Yes ☐ No ☐ Neither

Address: ____

____

Cell/other:___________________________________ May I leave a voice or text message? ☐ Yes ☐No

Home Phone:_________________________________ May I leave a message? ☐ Yes ☐ No

Email:_______________________________________ May I email you? ☐ Yes ☐ No

**NOTE: Emails may not be confidential*

Counseling Information

**Please note: The information is for counseling use only & is protected by the laws of confidentiality.*

Have you been to previous counseling? ☐ Yes ☐ No When: ____________ Duration: ____________

Major Issues Discussed: ____

What did you find helpful? ____

What did you find not helful?____

In the last year have you had any significant life changes or transitions (i.e. moving, illness, loss, relationship change etc.)? ____

____

In last 6 months I have experienced:

- ☐ Relationship Struggles
- ☐ Health Problems
- ☐ Employment Transitions
- ☐ Financial Struggles
- ☐ Parent/child Hardships
- ☐ Grief and Loss
- ☐ Flashbacks to Past Experiences
- ☐ Depressed Mood
- ☐ Rapid Speech
- ☐ Unnatural Anxiety
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Disturbed Sleep
- ☐ Hallucinations
- ☐ Memory Lapse or Loss
- ☐ Alcohol/substance Abuse
- ☐ Body Complaints
- ☐ Repetitive Thoughts
- ☐ Time Loss
- ☐ Repetitive Behaviors
- ☐ Trouble Planning
- ☐ Trouble Following Through
- ☐ New Trauma

Symptoms:

- ☐ Changes in Sleep
- ☐ Increased Anxiety
- ☐ Decreased Motivation
- ☐ Mood Swing
- ☐ Chronic Pain
- ☐ Decreased Concentration
- ☐ Decreased Energy
- ☐ Overspending
- ☐ Increased Irritability
- ☐ Body Aches
- ☐ Changes in Appetite
- ☐ Suicidal Thoughts
- ☐ Feelings of Hopelessness
- ☐ Anger/Rage
- ☐ Headaches

Why have you decided to seek counseling <u>now</u>?

____

____

____

____

Are you currently having thoughts of suicide*? ☐ Yes ☐ No Of Homicide*? ☐ Yes ☐ No

Have you attempted suicide in the past? ☐Yes ☐No

How many times? ________ When? ________________

Is there a history of suicide in your family? ☐ Yes ☐No With your friends? ☐Yes ☐No

Have you intentionally burned, cut, or hurt yourself? ☐Yes ☐No

How often? _______________ When was the last time?__________

**Please note: The law requires me to break confidentiality to save lives*

Employment & Education

Are you currently employed? ☐ Yes ☐ No

Place of employment: ___________________________________ Position: ___________________________________

Would you consider your job stressful? ☐Yes ☐No

Would you consider your job fulfilling? ☐ Yes ☐ No

Length of time: ______________ Do you like your job? ☐ Yes ☐ No Why? ___________________

____

Currently in school? ☐YES ☐NO If yes, where? ____

Furthest education: _________________________ Degree (if any):______________________________

Military History? ☐Yes ☐No If yes, ☐ Active ☐ Discharged ☐ Retired

Branch of Service: ___________________________ Highest Rank: ______________________________

Relationship History

Current Status: ☐ Single ☐ Married ☐ Divorced ☐ Cohabitating

On a scale from 1 (not so good) to 10 (great) how would you rate your current status? _____________

Describe your current or most recent relationship: ____

____

____

Are you sexually active? ☐ Yes ☐ No Do you ever look at porn? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No How many? _________

Child's Name	Age	Your relationship with him/her

Has their behavior changed recently? ☐ Yes ☐ No If so, how? ________________________________

____

Mental & Physical Health History

Have you ever been prescribed medication by a psychiatrist? ☐ Yes ☐ No

Medication Name:	Dosage:	Prescribed by:

**Please circle medications you are currently taking*

Have you ever been hospitalized for a physical injury or mental illness? ☐ Yes ☐ No If so, when? ____________ and why?__________________________________

Do you or your family members have a history of mental illness? ☐ Yes ☐ No

Issue		Family Member
Depression	☐ Yes ☐ No	______________________________
Anxiety Disorder	☐ Yes ☐ No	______________________________
Bipolar Disorder	☐ Yes ☐ No	______________________________
Panic Attacks	☐ Yes ☐ No	______________________________
Alcohol/Substance Abuse	☐ Yes ☐ No	______________________________
Eating Disorder	☐ Yes ☐ No	______________________________
Learning Disability	☐ Yes ☐ No	______________________________
Trauma History	☐ Yes ☐ No	______________________________
Domestic Violence	☐ Yes ☐ No	______________________________
Obesity	☐ Yes ☐ No	______________________________
Obsessive Compulsive Behavior	☐ Yes ☐ No	______________________________
Schizophrenia	☐ Yes ☐ No	______________________________
Other: ______________________		______________________________
______________________		______________________________

On a scale of 1(being worst) to 10(being best) how would you rate your physical health currently? ________

Can you list any physical symptoms or health concerns you have? ______________________________________

____

Are you on any medications for physical injury or illness? ☐ Yes ☐ No

Medication Name	Dosage	Prescribed By
____________________________	______________	____________________________________
____________________________	______________	____________________________________
____________________________	______________	____________________________________

Do you exercise regularly? ☐ Yes ☐ No If no, do you want to? ☐ Yes ☐ No

How many times per week do you exercise? ____________days ____________minutes/hours

Are there any changes or difficulties with your eating habits? ☐ Yes ☐ No

If yes, how so? ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced a significant weight change in the last 3 months? ☐ Yes ☐ No

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

If yes, how so? ☐ Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing dreams

Other: ____

Can you explain?____

Do you consume alcohol regularly? ☐ Yes ☐ No

In one month, how many times do you have 4 or more drinks in a 24-hour period? ______

Substance		How Often	Age of 1st Use	Last Use
Alcohol	☐ Yes ☐ No	____________	____________	____________
Tobacco	☐ Yes ☐ No	____________	____________	____________
Marijuana	☐ Yes ☐ No	____________	____________	____________
Other Drugs (specify)				
______________		____________	____________	____________
______________		____________	____________	____________

Have you experienced a recent increase in alcohol/other drug use? ☐ Yes ☐ No

Do you have family members with addictions? ☐ Yes ☐ No If so, what to? ________________________

Religious/Spiritual Information

Do you practice a religion? ☐ Yes ☐ No If yes, what is your faith? ______________________________

If no, do you consider yourself to be spiritual? ☐ Yes ☐ No

How important are religious/spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs to be incorporated into your counseling? ☐ Yes ☐ No
**This will only be brought up at your discretion and direction*

Other General Information

Please describe your social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐Students ☐ Co-workers ☐ Support/Self-Help Group

☐ Community Group ☐ Religious/Spiritual Center

Current Major Stressors in your life:

____

____

____

____

Major Source of Support in your life:

____

____

____

____

What are your areas of strength?

____

____

____

What are your areas that need development?

____

____

____

What do you like most about yourself?

____

____

____

What are so ways you cope with stress?

____

____

____

What are your goals for counseling? What would you like to achieve?

____

____

____

____

Do you want your family involved in your counseling? ☐ Yes ☐ No

If yes, how? ____

Emergency Contact

Name: ____

Relationship: ____

Phone Number: (________) ________________________________

Address: ____

____

Credit Card Information

I, ____ , am authorizing Rebecca Frank, MA, LPCC, of Courage to Connect Counseling, PLLC to use my credit card information to charge my credit card in the event of: missing an appointment, not giving 24 hours-notice to cancel an appointment for reasons other than medical concerns, or emergencies, forgetting payment at the time of session, or for general payment of counseling.

□ VISA □MasterCard □ American Express □Discover

Card Number:

__________-__________-____________-____________ Exp. Date: _______/_______ Security Code: ________

Billing Address: ____

City & State: ______________________________ Zip: ___________________

Email: ____

Phone : (_______) ____________________

By signing below I am authorizing Rebecca Frank, MA, LPCC of Courage to Connect Counseling, PLLC to charge the above-mentioned card for late cancellations, missed appointments, or any outstanding balances.

Card Holder Name (Print):

____

Card Holder Signature:

____ Date: ____________

Client Signature (if not card holder):

____ Date: ____________