

Anchored Vision: Family therapy Services, PLLC

* For couples, each partner should complete this intake.

Client Name: _____

Date of Birth: _____

Client Address: _____

May I correspond by email? Y / N

Email address: _____

Best number to reach you: (____) _____ - _____ Ok to leave message? Y / N

Client Social Security Number: _____

Person filling out form, if not client: _____ Relationship to client: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

(Initial here) _____ *I understand that my therapist may contact the emergency contact listed here if it is determined that the client's safety may be at risk.*

Are you involved in any legal proceedings (e.g. child custody dispute, divorce proceedings, etc) which may involve your therapist? Y / N If yes, please describe:

How did you hear about Anchored Vision Family Therapy Services, or who referred you to us? (Include phone number/email address of referring source).

Marital Status:

Single ____ Married ____ Divorced ____ Domestic Partner ____ Widowed ____ Other ____

Employment Status:

Full Time ____ Part Time ____ Full Time Student ____ Part Time Student ____ Unemployed ____

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy in the Disclosure Statement. If printing, use the back of form as necessary.

1) Briefly describe why you have decided to seek counseling now.

2) Please check any of the concerns or symptoms listed below that you are currently experiencing:

- | | |
|---|---|
| <input type="checkbox"/> marriage/relationship problems | <input type="checkbox"/> anger/irritability |
| <input type="checkbox"/> difficulties with family | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> difficulties with friends | <input type="checkbox"/> loss of temper/outbursts |
| <input type="checkbox"/> school problems | <input type="checkbox"/> Overindulgence |
| <input type="checkbox"/> step-family problems | <input type="checkbox"/> physical abuse of self (current or past) |
| <input type="checkbox"/> divorce issues | <input type="checkbox"/> verbal/emotional abuse (current or past) |
| <input type="checkbox"/> serious physical illness (self or family) | <input type="checkbox"/> loss of interest in previous activities |
| <input type="checkbox"/> health concerns (self or family) | <input type="checkbox"/> recurrent flashbacks |
| <input type="checkbox"/> fatigue/low energy | <input type="checkbox"/> trouble with memory or concentration |
| <input type="checkbox"/> death of family member or friend | <input type="checkbox"/> confusion |
| <input type="checkbox"/> anxiety/worry/nervousness | <input type="checkbox"/> much fantasy or daydreaming |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> hyperactivity/attention problems |
| <input type="checkbox"/> perfectionism | <input type="checkbox"/> headaches/stomach aches |
| <input type="checkbox"/> guilt/shame feelings | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> sexual identity concerns |
| <input type="checkbox"/> depressed mood/sadness | <input type="checkbox"/> identity concerns |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> feelings of unreality |
| <input type="checkbox"/> self-injury | <input type="checkbox"/> obsessive thoughts/excessive fears |
| <input type="checkbox"/> eating habits | <input type="checkbox"/> unusual thoughts or perceptions |
| <input type="checkbox"/> Bullying/ getting bullied | <input type="checkbox"/> excessive energy |
| <input type="checkbox"/> anger/irritability/outbursts | <input type="checkbox"/> impulsive decisions or actions |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> difficulty trusting others |
| <input type="checkbox"/> Screen/media Time | <input type="checkbox"/> low self-esteem |
| <input type="checkbox"/> aggressive/violent behaviors | <input type="checkbox"/> avoidance of conflict |
| <input type="checkbox"/> concern about alcohol/drug use | <input type="checkbox"/> withdrawn, isolating |
| <input type="checkbox"/> physical abuse of self (current or past) | <input type="checkbox"/> shy/uneasy around others |
| <input type="checkbox"/> verbal/emotional abuse (current or past) | <input type="checkbox"/> fear of failure |
| <input type="checkbox"/> reluctant to leave home or familiar neighborhood | <input type="checkbox"/> fear of disapproval |
| <input type="checkbox"/> concerns about behavior/habits/compulsions | <input type="checkbox"/> difficulty making independent decisions |
| <input type="checkbox"/> concern about lying or dishonesty with others | <input type="checkbox"/> feelings of futility/loss of hope |
| | <input type="checkbox"/> loss of joy in living |
| | <input type="checkbox"/> physical abuse of others |
| | <input type="checkbox"/> Problems at work or work/life balance |

Check the response which best applies.

My current concerns and symptoms are:

- Continuation of a long-standing condition
- Recent worsening of an on-going condition
- The reoccurrence of a previous condition
- Significantly different from any previous condition

My current symptoms developed:

- My first occurrence of any condition
- Suddenly (within the past 4 weeks)
- Gradually (one to several months ago)
- Very gradually (over the past year or longer)

GOALS AND SUPPORT NETWORK:

What specific goals would you like to accomplish during your time in therapy?

- 1.
- 2.
- 3.

Of these goals, what would you like to have happen first? How do you think your life will be different when you complete your goals?

How hopeful are you that things can get better?

Who in your family supports you?

Who outside of your family supports you (extended family, community supports such as doctors, teachers, case managers, neighbors, clergy and friends)?

What are your typical self-care practices (hobbies, joyful activities, stress reducers)?

What are your strengths/ what do you like about yourself?

What are your family's strengths?

Do you consider yourself to be spiritual or religious? Y / N

If you'd like, briefly describe your faith, denomination, or belief:

Do you feel most recharged and stimulated when you are alone or when you are with other people? In other words, do you consider yourself to be an introvert or an extrovert?

Describe your family's heritage/ethnicity:

What celebrations or holidays do you and/or your family celebrate?

What do you consider to be your gender identity:

Male ___ Female ___ Transgender ___ Androgynous ___ Questioning ___ Other ___

Describe your sexual identity:

Gay ___ Straight ___ Bisexual ___ Asexual ___ Questioning ___ Other ___

Is there anything else to know in order to be respectful of you and/or your family's beliefs and background?

Do you want to address any of these issues in counseling?

Please briefly describe your:

Educational/occupational history

Legal history (arrest history, sentencing, incarceration, litigation, etc.)

Military involvement

Family Relationships

Spouse/Significant Other: _____ Age: _____

Children (Please list names and ages):

Parents (Please list names and ages):

Other important family members:

Briefly describe your current family situation and relationship history

Are you currently in a romantic relationship? Y / N

If yes, for how long?

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

What do you consider to be some of your strengths/what do you like about yourself?

What do you consider to be some of your areas for growth?

HEALTH HISTORY:

1. How would you rate your current physical health?

Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very good ___

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits?

Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very good ___

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you typically participate in?

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression? ___ No ___ Yes

If yes, for approximately how long?

6. Are you currently experiencing anxiety, panics attacks or have any phobias? ___ No ___ Yes

If yes, when did you begin experiencing this?

7. Are you currently experiencing any chronic pain? ___ No ___ Yes

If yes, please describe:

8. Please list major injuries, illnesses or surgeries.

Condition _____ Dates _____

Treatment _____

Current and past medications:

Medication _____ Dosage _____

Prescribing Physician _____

Date Started _____

9. Allergies/Sensitivities to medications:

Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.)

Have you ever previously received a mental health diagnosis (e.g. depression, anxiety, bipolar, ADHD, OCD, etc)? If yes, what, when, and by whom?

Has anyone in your immediate or extended family had a mental health diagnosis (e.g. depression, anxiety, bipolar, ADHD, OCD, etc)? Please list relationship and nature of diagnoses?

When was client's last physical exam?

Any problems noted at last physical?

Please rate the overall level of stress that you feel is currently pressing on you, including life changes, work, family, and finance. (Circle appropriate number)

1 2 3 4 5
minimal moderate extreme

Comment:

Do you currently have thoughts about hurting yourself or others? Please describe.

Have you ever had thoughts about hurting yourself or others? If yes, please describe.

Do you drink alcohol more than once a week? ___ No ___ Yes
If yes, how much per week is normal for you? Does your drinking concern you?

How often do you engage in recreational drug use?

_____ Daily _____ Weekly _____ Monthly _____ Infrequently _____ Never _____

What significant life changes or stressful events have you experienced recently?

Any other concerns? Please list them below.