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:

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____ withdrawn, isolating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

In thinking about your network of friends, family, etc., how would you rate the amount of helpful social support currently available to you.

1	2	3	4	5
None		Some, but not adequate		Adequate

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Are there any other significant events that have taken place in your family history that you wish to share at this time?

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.