Licensed Counselors, Life Coaches, & Executive Coaches

7758 Wallace Rd, Suite 6, Orlando, FL 32819 P: 407-355-7378
F: 407-641-8680
www.LifeSkillsResourceGroup.com

CONFIDENTIAL CLIENT INTAKE FORM

Name: ______________________________ **Age:** _______ **Date of Birth:** __________________

Gender: Male Female Transgender: M to F Transgender: F to M

Home Address: ____

Mailing Address if different than Home: ____

Email Address:______________________________________**May we email you?** **Yes** **No**

Best Contact Phone number: ________________________________

Emergency Contact Name____________________**Relationship**________________**Phone**______________________

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

White/Caucasian African-American Black African Asian-American Asian or Pacific Islander Hispanic-American
Latino/Latin American/Hispanic Arab-/Middle Eastern-American Arab**/**Middle Eastern Native American
Alaskan Native Multiracial Other

Specify: ____

How much do you identify with your ethnic heritage?

Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list:

____

Religious preference: ____

Are you currently active in your religion?

Yes Somewhat No

Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process?

Yes No I Don't Know

ACADEMIC/ WORK BACKGROUND:

Place of employment: ____

Hours worked per week:____________ **Years with employer:** ________________

Position: ____

Are you satisfied with your job? Yes No I Don't Know

Highest Educational Degree: ____

Major: ____

Are you a student? Yes No **If yes, where are you studying:** ______________________________

RELATIONAL HISTORY:

Please indicate your current relationship status:

Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed

Other: ____

Approximately how many significant romantic relationships have you had? ______________________________

How many times have you married? _______

What are the dates of your marriage(s) and divorce(s)? ______________________________

If you are in a romantic relationship, how long have you been in this relationship? ______________________________

If you are married, how long did you know your spouse/partner before marriage? ______________________________

Are you satisfied with your current romantic relationship? Yes No I Don't Know

Do you feel supported by your partner/spouse? Yes No I Don't Know

FAMILY/FRIENDS BACKGROUND:

Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student, 12; partner, M, doctor, 35):

Family Member	Occupation	Age

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Your Family's Religious/Spiritual Background: ____

How much conflict do you currently experience with your family (whether living with you or not)?

None Very little Some Moderate Strong Extreme

Have you experienced any significant death in your family? Yes No

Are you a twin? Yes No

Please list any step-parents ____

How many brothers do you have?_______ **Ages of brothers** _________________________

How many sisters do you have?______ **Ages of sisters** __________________________

How many sons do you have?_______ **Ages of sons** ____________________________

How many daughters do you have?______ **Ages of daughters** ________________________

Has there been any adoption within your family? Yes No

How would you rate the quality of your friendships?

Very Poor Unsatisfactory About Average Good Excellent

Besides family, how many people can you count on right now for friendship/emotional support? _______________

How well are you getting along with each of the following persons?
(Choose a number between 1 and 10, with 10 being very well and 1 being very poorly.)

Mother _________ **Father** _________ **Sister(s)** _________ **Brother(s)** _________ **Spouse/Partner** _________

Female Child(ren) _________ **Male Child(ren)** _________ **Friend(s)** __________

PHYSICAL HEALTH:

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

When was your last physical examination? ____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Do you have a disability? No Yes **Specify:**

Are you presently taking any prescribed medication? Yes No

Please list all medications, the reason for which each is prescribed, name of prescribing physician (e.g.: Paxil/ social anxiety/Dr. Joseph):

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Name of your primary care physician: ____

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

Are you having any difficulty with appetite or eating habits? No Yes

Have you had a significant weight change in the last 2 months? No Yes

Do you have any problems or worries about sexual functioning? No Yes

How many times per week do you exercise?____________________**For how long each time?** ________________

MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank for now)*

Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child

Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse Sexual abuse/assault as an adult

Other Trauma **Specify**:____

Have you received counseling here or elsewhere before? Yes No

If yes, where:________________________________**When:**__________________**Duration:** ___________

What was the focus of previous counseling?

____

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No

If yes, where:________________________________**When:**__________________**Duration:** ___________

What was the focus of the psychiatric treatment?

____

Were you EVER prescribed psychiatric medications? Yes No

What medications and for what reason?

____

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: ____

How often are you having thoughts of harming others presently? Frequently Sometimes Rarely Never

How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never

When: ____

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: ____________________

Have you ever attempted suicide? Yes No **Date(s):**____________________

Have you ever been hospitalized for psychological reasons? Yes No

Date(s): ____________________

Have any of your family members (parents, grandparents, siblings) had psychological issues? Yes No

If so, please describe: ____________________

____

____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

In a typical week, on how many days do you have 4 or more drinks? ____________________

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

Do you or does someone else think that you may need to cut down or stop using other drugs?

Yes No Maybe

PROBLEM ANALYSIS:

Briefly describe the problem you most wish help with right now:____________________

____

____

____

How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 (not intense) 2 3 4 5 6 (extremely intense)

How much has your current problem interfered with your life in general?

Not at all A little Somewhat Moderately To a great extent

In what ways have you attempted to cope with this problem?

____

____

____

____

How many counseling sessions do you anticipate needing?

1-3 4-6 7-9 10-12 13-15 16-20 20+

How motivated are you to resolve this problem?

Not at all A little Somewhat Moderately Extremely

Why have you decided that now is the time in your life to take action to resolve this problem?

____

____

____

____

How hopeful are you that this problem can be resolved?

Not at all A little Somewhat Moderately Extremely

List your strengths and qualities you admire about yourself:

____

____

____

____

When our work together has been successful, what differences will you notice in yourself?

____

____

____

____

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

______________________	______________________	____________
Client Name (print)	Client Signature	Date

Name:_________________________________ Date: _____________

Burns Depression Checklist

Instructions: Indicate how much each of the following 15 symptoms has been bothering you in the past several days.	0 - Not at all	1 – Somewhat	2 - Moderately	3 - A lot
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look bleak or hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a loser?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability and frustration: Have you been feeling angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a lot about your health?				
15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead?				

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Name: ________________________________ Date: ____________

Burns Anxiety Inventory

Instructions: Indicate how much each of the following 33 symptoms has been bothering you in the past several days.

	0 - Not at all	1 - Somewhat	2 - Moderately	3 - A lot
CATEGORY 1: ANXIOUS FEELINGS				
1. Anxiety, nervousness, worry, or fear				
2. Feeling things around you are strange or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stress, "uptight" or on edge				
CATEGORY 2: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of illnesses, heart attacks or dying				
14. Fears of looking foolish in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible will happen				
CATEGORY 3: PHYSICAL SYMPTOMS				
18. Skipping, racing or pounding of the heart				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

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