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Festus, Missouri
(636) 465-0760
www.withinyoucounseling.com

INTAKE & CLIENT INFORMATION

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____ Administrative Sex: _____ Gender: _____

Pronouns: _____ Sexual Orientation: _____ Race: _____

Ethnicity: ☐ Latino/Hispanic ☐ Not Latino/Hispanic

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____

Is it ok to leave a detailed message? ☐ YES ☐ NO

Is it okay to text? ☐ YES ☐ NO

Email: _____

Is it okay to send email communication? ☐ YES ☐ NO

Is it ok to send something in the mail? ☐ YES ☐ NO

How did you find me? _____

Reasons for Seeking Therapy

Please list the 3 biggest problems/concerns/issues you have right now.

Primary Concern: _____

☐ Mild ☐ Moderate ☐ Severe ☐ Intermittent

Onset: _____

☐ Getting Worse ☐ Getting Better ☐ No Change

Solution/coping skills you have tried to manage/resolve this concern:

_____

Second Concern: _____

☐ Mild ☐ Moderate ☐ Severe ☐ Intermittent

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Onset: _____

☐ Getting Worse ☐ Getting Better ☐ No Change

Solution/coping skills you have tried to manage/resolve this concern:

_____

Third Concern: _____

☐ Mild ☐ Moderate ☐ Severe ☐ Intermittent

Onset: _____

☐ Getting Worse ☐ Getting Better ☐ No Change

Solution/coping skills you have tried to manage/resolve this concern:

_____

Do you feel you have some control over your present situation? _____

Have you had therapy in the past? _____

If yes, was it helpful &how? _____

Mental Health Information

	Yes	No
Have you been previously diagnosed with a mental health disorder?	☐	☐
Have you received psychiatric services in the past?	☐	☐
Do you have recurring nightmares or flashbacks?	☐	☐
Did you experience any developmental delays growing up?	☐	☐
Have you ever been treated for drug and/or alcohol dependency?	☐	☐
Are there any addictive behaviors present?	☐	☐
Do you currently use recreational drugs?	☐	☐
Do you participate in risky behaviors?	☐	☐
Have you ever or do you currently hear voices/see things others do not hear/see?	☐	☐
Have you ever or do you currently have delusions?	☐	☐
Have you ever been diagnosed with ADD/ADHD?	☐	☐
Have you suffered from any recent losses?	☐	☐
Do you tend to isolate from others?	☐	☐

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	Yes	No
Do you tend to avoid anything that is uncomfortable or painful?	☐	☐
Are you generally impulsive?	☐	☐
Do you struggle to feel pleasure?	☐	☐
Do you have rapid mood swings?	☐	☐
Do you tend to be indecisive?	☐	☐
Do you feel you have good problem-solving skills?	☐	☐
Do you struggle asking for help when needed?	☐	☐
Are you hopeful about the future?	☐	☐
Do you feel life is meaningful?	☐	☐

Are you currently receiving psychiatric services? _____

If yes, please list name, address, and phone numbers of providers:

_____

Please list any psychiatric hospitalizations; places, dates, reason:

Please explain what your life purpose is:

_____

Important Questions We Must Ask

	Yes	No
Have you ever had thoughts of killing yourself?	☐	☐
Have you ever planned on killing yourself?	☐	☐
Have you ever attempted to kill yourself?	☐	☐
Are you having current suicidal ideation?	☐	☐
Has anyone in your family or close to you died by suicide?	☐	☐
Have you ever or are you currently self-harming (cutting, burning, etc.)?	☐	☐
Have you ever felt you wanted to seriously harm or kill someone else?	☐	☐
Are you having current homicidal ideation?	☐	☐

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	Yes	No
Are there weapons in the home?	☐	☐
Do you have access to weapons?	☐	☐
Do you have a history of abuse or violence?	☐	☐
Is there any current abuse or violence present?	☐	☐

Medical/Wellness

Do you currently have a primary care provider? ☐YES ☐NO

If yes, please list name, address, and phone number of your primary care provider:

_____

Are you currently under a physician's care? ☐YES ☐NO

How would you rate your physical health? ☐Excellent ☐Good ☐Fair ☐Poor

Last Physical Exam Date: _____ Last Pap: _____

Last Mammogram: _____ Last Prostate Exam: _____

Height: _____ Current Weight: _____

	Yes	No
Are you interested in losing or gaining weight?	☐	☐
Have you lost or gained weight in the past 6 months?	☐	☐
Have you lost or gained weight in the past year?	☐	☐
Do you use contraceptives?	☐	☐
Have you ever or do you currently smoke, vape, or use chewing tobacco?	☐	☐
Do you wear contacts or glasses?	☐	☐
Do you have any allergies or sensitivities?	☐	☐
Were you breastfed?	☐	☐
Did you take antibiotics as a child?	☐	☐
Do you tend to overeat, binge, or restrict food?	☐	☐
Do you participate in any form of fasting?	☐	☐
Have you or are you currently participating in a detox method/program?	☐	☐
Do you consume caffeinated beverages?	☐	☐
Do you consume sweetened beverages?	☐	☐
Do you use artificial sweeteners?	☐	☐

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	Yes	No
Do you consume alcohol?	☐	☐
Do you have trouble sleeping?	☐	☐
Do you wake up feeling rested?	☐	☐
Do you exercise regularly?	☐	☐
Do you suffer from any chronic pains or aches?	☐	☐
Have you ever experienced a head trauma?	☐	☐
Have you seen any specialists in the past?	☐	☐
FEMALES ONLY		
Are you or could you be currently pregnant?	☐	☐
Are you in perimenopause or menopause?	☐	☐
Are you experiencing any menopausal symptoms?	☐	☐
Did you experience any birth complications with any of your children?	☐	☐
Have you ever had an abortion?	☐	☐
Have you ever had a miscarriage?	☐	☐

Are you currently seeing any specialists? _____

If yes, please list name, address, and phone numbers of providers:

List any surgeries including dates:

List any serious accidents including dates:

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List any serious injuries including dates:

List any medical hospitalizations including places and dates:

Stress Level: ☐ Extreme ☐ High ☐ Moderate ☐ Mild ☐ Low

Causes of stress: ☐ Financial ☐ Family ☐ Career/School
☐ Spiritual ☐ Friends ☐ Marriage/Relationship
☐ Physical Health ☐ Mental Health ☐ Other _____

On average, how many hours do you sleep each night? _____

What time do you go to sleep? _____ Awaken? _____

Check all conditions that apply:

	Now	Past	Family Hx		Now	Past	Family Hx
Headaches	☐	☐	☐	Migraines	☐	☐	☐
Fatigue	☐	☐	☐	Chronic ear infections	☐	☐	☐
Sinus infections	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐
Osteoarthritis	☐	☐	☐	Lupus	☐	☐	☐
Spasms, cramps	☐	☐	☐	Spinal problems	☐	☐	☐
Tendonitis	☐	☐	☐	Stiff or painful joints	☐	☐	☐
Ringing in the ears	☐	☐	☐	Dizziness	☐	☐	☐
Vertigo	☐	☐	☐	Loss of memory	☐	☐	☐
Numbness, tingling	☐	☐	☐	Sciatica	☐	☐	☐
Heart disease	☐	☐	☐	Blood clots	☐	☐	☐
Stroke	☐	☐	☐	High/low blood pressure	☐	☐	☐
Asthma	☐	☐	☐	Bowel dysfunction	☐	☐	☐
Gas, bloating	☐	☐	☐	Abdominal pain	☐	☐	☐
Bladder dysfunction	☐	☐	☐	Kidney dysfunction	☐	☐	☐
Ulcers	☐	☐	☐	Diarrhea	☐	☐	☐

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	Now	Past	Family Hx		Now	Past	Family Hx
Constipation	☐	☐	☐	Nausea	☐	☐	☐
Gallbladder attacks	☐	☐	☐	Fibromyalgia	☐	☐	☐
Crohn's disease	☐	☐	☐	Irritable bowel/colitis	☐	☐	☐
Thyroid dysfunction	☐	☐	☐	Diabetes	☐	☐	☐
Fibrocystic cysts	☐	☐	☐	Cancer	☐	☐	☐
Reproductive problems	☐	☐	☐	PCOS	☐	☐	☐
Hemorrhoids	☐	☐	☐	Lymphedema	☐	☐	☐
Irregular heartbeat	☐	☐	☐	Canker sore/fever blister	☐	☐	☐
GERD/heartburn	☐	☐	☐	Seizures	☐	☐	☐
Blackouts	☐	☐	☐	Anemia	☐	☐	☐
Restless leg syndrome	☐	☐	☐	Other	☐	☐	☐

You eat a healthy balanced diet: ☐ Always ☐ Often ☐ Sometimes ☐ Never

You avoid excess sugar: ☐ Always ☐ Often ☐ Sometimes ☐ Never

You crave sugar/sweets: ☐ Always ☐ Often ☐ Sometimes ☐ Never

Please list all medications, supplements, and vitamins:

Medication	Reason Prescribed	Dosage	Frequency	Date Began	Helpful? Y/N

Career/Job/Education

Employment Status: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed
☐ Retired ☐ Disabled ☐ Student ☐ Other

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Place of Employment: _____ Work Number: _____

Current occupation/position? _____

How long have you been in your current position? _____

How many hours each day do you work? _____

Household gross monthly income: _____

Job Satisfaction: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have a financial budget? ☐ YES ☐ NO

Have you ever served in the military? ☐ YES ☐ NO

Highest level of education:
☐ Less than 12th Grade ☐ GED
☐ Graduated High School ☐ Some College
☐ Associates ☐ Bachelors
☐ Masters ☐ Doctorate

Name of High School: _____

Name of College: _____

Major/Minor in College: _____

Average grades in school: ☐ A ☐ B ☐ C ☐ D ☐ F

Do/did you participate in extra-curricular activities? ☐ YES ☐ NO

Have you ever had any learning problems or disabilities? ☐ YES ☐ NO

Recreation and Leisure

Do you have a daily self-care practice? ☐ YES ☐ NO

How many times do you practice a form of relaxation per week? _____

How many times do you eat out per week? _____

How many vacations do you take each year? _____

When was your last vacation? _____

Do you feel you have balance in your life? ☐ YES ☐ NO

Do you manage time well? ☐ YES ☐ NO

Do you have hobbies and/or interests? ☐ YES ☐ NO

Which social media sites do you use:
☐ Facebook ☐ Twitter
☐ Linkedin ☐ Instagram
☐ Snapchat ☐ TikTok
☐ Other: _____

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How much time on average do you spend on social media each day? _____

Intimate Relationships

Current Marital Status: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed ☐ Living Together

Number of Marriages: _____ Length of Recent Marriage: _____

Relationship Satisfaction:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Sex Satisfaction:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Communication:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Please describe your current or most recent relationship:

Family

Names, relationships, and ages of others currently living in the home:

_____

How many dependents do you have? _____

How many children do you have? _____

Do you have any pets? ☐ YES ☐ NO

Parent's marital status: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed ☐ Living Together

Please indicate the **current** relationship you have with your

Mother:	☐ Close	☐ Distant	☐ Strained	☐ Non-Existent	☐ Deceased
Father:	☐ Close	☐ Distant	☐ Strained	☐ Non-Existent	☐ Deceased
Siblings:	☐ Close	☐ Distant	☐ Strained	☐ Non-Existent	☐ Deceased

Please describe the relationship you had with your mother growing up:

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Please describe the relationship you had with your father growing up:

If applicable, please describe the relationship you had with any stepparents growing up:

How many siblings do you have? _____

Birth Order: _____

If applicable, please describe the relationship you had with any siblings growing up:

Were you ever adopted? ☐ YES ☐ NO

Were you ever in foster care? ☐ YES ☐ NO

Please describe your upbringing/childhood: (Did your parents work, if so who watched you? Were your parents strict or not? Did you have a lot of rules and responsibilities? Were your parents involved? Did you play sports or belong to any clubs? Did you have friends? Did you go to church? Etc.)

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Please describe your family's history of **medical** issues or hereditary diseases:

Please describe your family's history of **mental health** concerns:

Please describe your family's history of substance use/alcohol issues:

If applicable, please describe your family's history of legal issues:

Social Supports

Please describe your current friendships:

Do you have any social supports? (clubs, agencies, or community organizations)	☐ YES	☐ NO
Do you belong to any religious or spiritual groups?	☐ YES	☐ NO
Do you actively participate in any spiritual/religious practice(s)?	☐ YES	☐ NO
Do you have any past legal issues/concerns?	☐ YES	☐ NO
Do you have currently legal issues/concerns?	☐ YES	☐ NO

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Change is Coming…

What are your expectations from therapy?

_____

What are your expectations of the therapist?

_____

Looking into the future, how will you know that our work and time together has been worth it?
List concrete changes you will see:

Do you foresee any obstacles to achieving your goals or the desired changes? ☐ YES ☐ NO

How long do you think therapy will need to last to achieve your goals? Write down a target date:

_____

List 5 strengths about yourself or that others say about you:

1. _____
2. _____
3. _____
4. _____
5. _____

Please complete the following sentence:

I am _____, people are _____, and the world is _____.

Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

