Clients name _____DOB_____

Age_____Gender_____ With what Race/Ethnicity do you most closely identify_____

I. Family of Origin

A. Where were you born/raised? _____

B. Do you have any siblings? Y_____ N _____
Sibling(s)' names and ages:

What is the birth order of the client? (oldest, middle, etc.) _____

What was it like to be in that position in the family?

C. Are your parents still alive? Y____ N____

Have they ever been married? Y____ N____

Are your parents still married? Y____ N____

Divorces/separations/step-parents? Y ____ N ____

What are your living arrangements? _____

Parents' nationality: Mother _____

Is English her primary language? Y____ N____

Father _____

Is English his primary language? Y____ N____

Parents' occupation: Mother _____

Father _____

INTAKE INTERVIEW FORM
(page 2)

D. Family Mental Health History:
Anyone have history of drug abuse? Y ___ N ___
Who?

Alcohol addiction? Y ___ N ___
Who?

Mental illness, emotional disorders (depression, anxiety, schizophrenia)?
Who?

Learning disabilities (mental retardation, literacy deficits, hyperactivity) ?
Who?

E. Have you ever been involved with the legal history? _____ If so, please explain. _____

_____

F. Concerns re: family of origin _____

_____

II. Occupation/Education:
Highest level of education achieved? _____

How well do you read and write? _____

Where do you go to school? _____

Any special education programs? Y ___ N ___
Explain:

What type of student are you? _____

What are your likes/dislikes about school? _____

_____

_____

Current job? _____

Past employment positions (most recent to past):

Any job-related disabilities? Y ___ N ___
Explain:

Concerns re: school/education

INTAKE INTERVIEW FORM
(page 3)

III. Medical/Health History

Are you under a doctor's care? Y ____ N ____

Dr.'s name/phone number _____

_____

Do you have any allergies? N_____ Y_____, list _____

Are you currently taking any prescribed medication? Y ____ N ____

Type of medication (s) _____

_____

Other than antibiotics, have you been on prescription medication in the past? Y____ N____

List: _____

Do you have any major health related concerns? Y ____ N ____

List: _____

Does your family have a history of health related concerns? Y ____ N ____

Do you smoke cigarettes? Y ____ N ____ How many? _____

Do you ingest caffeine? Y ____ N ____ How much? _____

Do you drink alcohol? Y ____ N ____ How much? _____

Do you ingest non-prescription drugs? Y ____ N ____

What types? _____

Concerns re: medical/health status: _____

_____

_____

_____

_____

_____

Any past trauma/abuse?_____

_____

_____

INTAKE INTERVIEW FORM (for Parents to fill out)

Please check present symptoms:

	Always	Sometimes	Never
Complains of aches and pains			
Spends more time alone			
Tires easily, little energy, sleeps a lot			
Has trouble with teacher/boss			
Less interested in school/work			
Acts as if driven by a motor (hyperactive)			
Impulsive, acts without thinking			
Distracted easily			
Afraid of new situations			
Feels sad, unhappy			
Is irritable, angry			
Feels hopeless			
Has trouble concentrating			
Less interested in friends			
Fights with others			
Hurts others intentionally			
Abusive to animals			
Cannot be trusted alone			
Lies frequently			
Inappropriate sexual behavior			
Hurts self on purpose			
Steals			
Is shy			
Absent from school/work			
School/work performance dropping			
Is down on her/himself			
Has trouble sleeping			
Eats poorly or history of eating disorders			
Worries a lot			
Wants to be with you more than before			
Feels he or she is bad			

INTAKE INTERVIEW FORM
(page 4)

	Always	Sometimes	Never
Takes unnecessary risks			
Gets hurt frequently			
Seems to be having less fun			
Acts younger than other his/her age			
Does not listen to rules			
Does not show feelings/emotions			
Does not understand others feelings			
Teases or is verbally abusive to others			
Blames others for troubles			
Voices from nowhere			
Recent weight loss or gain and amount_____			
Recent illness, virus or injury			
Irrational fears			
Has slowed or racing thoughts			
Disoriented			
Worries about things			
Labile (frequent mood swings)			
Has difficulty making decisions			
Feels guilty			
Has crying spells			
Has unusual thoughts			
Has irrational fears			
Is tense			
Has memory problems			
Panics over things			
Compulsive			
Others: (list)			

Are you suicidal or thinking of hurting yourself? _____ Or someone else ? _____

Do you commit to talking to your counselor first should you feel seriously suicidal? _____

Date (s) and place (s) of previous out-patient counseling _____

INTAKE INTERVIEW FORM
(page 5)

Date (s) and place (s) of previous psychiatric treatment/hospitalization _____

_____

Date (s) and place (s) of chemical dependency treatment _____

_____

Have you ever attended AA or anything similar? _____

Have you ever attempted suicide or tried to harm yourself? (when and how) _____

_____

Have you ever attempted to harm someone else? (when and how) _____

Have you ever taken a psychological test? (when and where) _____

IV. Social/Leisure Activities:

List your preferred leisure activities (hobbies, groups/organizations pastimes).

_____

_____

How many close friendships have you established? _____

How often do you engage in social activities? _____

How often do you engage in family activities? With whom? _____

_____

Concerns re: social/leisure activity _____

_____

V. AAT (Animal-Assisted Therapy) Experiences:

Animal experiences _____

Have you ever had a pet? _____

What happened to it?_____

Any AAT previously? _____

Concerns re: animals, fears, environment, etc? _____

VI. Religious Background:

Do you have a preferred denomination? __Y __N

Which ? _____

INTAKE INTERVIEW FORM
(page 6)

What is/was your family's primary denomination? _____

Are you currently active in a church? __Y __N

Describe _____

Concerns re: religion/spiritual _____

VII. Goals:

What do you want from your counselor in your therapy experience? _____

_____

What do you want to change in your own behavior or attitude? _____

_____

Or in your situation? _____

_____

Do you believe you need medication? Yes ____ No ____

Are you open to medication? Yes ____ No ____

Do you believe you need hospitalization? Yes ____ No ____ Why? _____

_____

_____

Is your parent or family member willing to come in if necessary? Yes _____ No _____

Are they willing to support your changes in other ways? (verbally, reading, etc.) Yes_____ No_____

Please list the exact transformation goals you have for therapy:

_____ _____

Client's signature Date