Center for Transformative Counseling, Inc.

801 Georgia Street
Key West, FL 33040
305-407-7676

Counseling Intake

Identifying Information

Name_____
Nickname/Name you want to be called_____
Address_____
_____
Phone Numbers (home, work, cell)_____
Email Address_____
Date of Birth_____
Gender ____
Ethnicity_____
Marital/partnership status_____
Close friend/relative we may contact in case of an emergency_____
Relationship to you _____
Address_____
Phone Number_____
Referred by_____

**Note: If you need more space to answer any of the questions below, please use the back of the sheet, indicating the question number you are responding to.*

Current Social Information

1. Describe your present living arrangements (with whom do you live) and briefly describe these relationships_____
_____
_____

2. How long have you been married/dating/living together? Describe this relationship (include occupation and age of significant other)_____
_____
_____

3. How many children do you have? (Name, sex, age)_____
_____
_____

4. Are there any significant problems with any of these children? (Describe)__
_____
_____

5. Give details of previous relationships/marriages_____
_____
_____

6. Any history of abuse (emotional, physical, sexual, verbal) in current or previous relationships_____
_____

Family History

7. Describe your childhood and adolescence (include home atmosphere, relationship with parents)_____
_____
_____
_____

8. Significant life events_____
_____
_____
_____

9. List mother and father by name, age, occupation_____
_____
_____

10. List siblings by name and age and describe how you relate to them (past and present)_____
_____
_____
_____

11. Have any family members been treated for/have emotional problems? Describe
_____
_____

Loss History

12. List type and dates of any traumatic losses (death, serious illness/disability, divorce, separation, job loss, retirement, loss of home/relocation)_____
_____
_____

13. List type and dates of other changes that resulted in loss (moving, graduation, abuse, change in social status and/or friendships, etc.)_____

Spiritual History

14. Religious affiliation history_____

15. Describe views on spirituality (God, life after death, meaning of life, connection with something greater than self, etc.)_____

Substance Abuse History

16. Any family history of drug and/or alcohol usage? List and describe_____

17. Any personal history of drug/alcohol usage? List and describe _____

18. Describe any change in your pattern of drug/alcohol usage in the past 6 months to 1 year_____

19. Have you ever had a DUI? No____ Yes____
    If more than one, how many?_____

Medical History

20. Describe any previous experiences with psychiatrists and/or counselors____

_____

21. Describe any illnesses you have presently and give the name of your attending physician_____
_____
_____

22. What prescription medications are you taking_____
_____

Educational History

23. Last degree and major or grade completed_____

24. Where did you go to school (high school, college, vocational, etc.)_____
_____
_____

25. Describe your school experience (was it positive or problematic, truancy, suspensions, special education, gifted program, etc.)_____
_____
_____
_____

Employment History

26. Present employment status and where (include positive and negative aspects of what is going on at work)_____
_____
_____
_____

27. Present income_____

28. If on leave of absence or disability, will you return to present job?_____
_____

Social Activities and Interests

29. List clubs and organizations you belong to_____
_____
_____

30. What do you do for fun and/or relaxation_____
_____

31. Skills/strengths/talents_____

Self-Assessment

32. Check all that apply to you:

__Depression
__Low energy
__Low self-esteem
__Poor concentration
__Hopelessness
__Worthlessness
__Guilt
__Sleep disturbance (more/less)
__Appetite disturbance (more/less)
__Headaches
__Thoughts of hurting yourself
__Thoughts of hurting someone
__Isolation/social withdrawal
__Sadness/loss
__Crying
__Stress
__Anxiety
__Panic
__Heart pounding/racing
__Chest pain
__Trembling/shaking/dizziness
__Sweating
__Chills/hot flashes
__Tingling/numbness
__Fear of dying
__Fear of going crazy
__Fear of being alone
__Nausea
__Phobias
__Obsessions/compulsive behaviors
__Thoughts racing
__Easily distracted/can't hold onto an idea
__Easily agitated/annoyed
__Excessive behaviors (spending, gambling)
__Delusions/hallucinations
__Confusion/not thinking clearly
__Feeling that you are not real
__Feeling that things around you are not real
__Lose track of time
__Unpleasant thoughts won't go away
__Anger/frustration
__Defy rules/authority
__Blame others
__Argue
__Excessive use of drugs and/or alcohol
__Excessive use of prescription medications
__Blackouts
__Physical abuse issues
__Sexual abuse issues
__Spousal abuse issues
__Feeling vulnerable/unsafe
__Loneliness/emptiness
__Overwhelmed
__Afraid
__Emotionally numb
__Jealous
__Over-protective
__Resentful
__Frequent illnesses/accidents
__Hypervigilant/startle easily
__Restless/constantly busy
__Feeling lost
__Spiritual questioning

Present Situation

33. What/who seems to be placing the most stress on you right now?_____
_____
_____
_____

34. Are there any legal issues pending? No____ Yes____ Describe_____
_____
_____

35. Are you having any financial problems at this time?_____
_____

36. What would you like to accomplish in therapy?_____
_____
_____

37. Is there anything important that we have not asked?_____
_____
_____
_____

Type of Therapy

38. What kind of therapy would you prefer? (You may indicate more than one choice.)
____Online Chat Therapy
____Email Therapy
____Telephone or WebCam Therapy
____Face to Face (available in Key West, FL area only)

I hearby avow that I am 18 years old or over and will present ID upon request.

_____
Client Signature Date

If you are under 18 years old, parent/guardian signature is required.
Parent/Guardian Name_____
Relationship to Minor_____
Date_____
Signature_____