Clarity Coaching and Counseling Intake Form

Please complete each section as thoroughly as possible

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number: (circle type-cell -home -work)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave a message on primary phone’s voicemail?

(circle one)

Yes

No

Alternate Phone Number: (circle type-cell- home -work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave a message on alternate voicemail? (circle one)

Yes

No

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I send an email to this address?

(circle one)

Yes or No

Marital status (Please circle):

Single

Married

Divorced

Separated

Widowed

Partnered

Emergency contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received counseling before? \_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For treatment of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ho was the counseling experience for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcohol? \_\_\_\_\_\_\_\_\_ How much/often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs?

\_\_\_\_\_\_\_\_Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco?\_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to reduce or eliminate use of these substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any suicidal thoughts?: \_\_\_\_\_\_\_\_\_\_

If Yes, when?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened?

(such as, did you go to the hospital, talk to someone, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever try to hurt yourself or end your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any current suicidal thoughts?\_\_\_\_\_\_\_\_\_ Do you have a plan?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_

Do you have any homicidal thoughts?\_\_\_\_\_\_\_\_

Do you have a plan?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any mental health diagnosis that someone has discussed with you in the past? If

yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_

Do you have any medical conditions? If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any prescribed medications? If yes, please list below:

Name of medication

What does it treat

List any medical or psychiatric conditions, including substance abuse, of your parents/siblings:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any religious and/or spiritual beliefs that you would like me to be mindful of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU PRESENTLY INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION,

LAWSUITS OR DIVORCE AND CUSTODY DISPUTES? (if

yes, please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What gives you most joy or pleasure in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main worries and fears? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your most important hopes or dreams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please write a brief description of primary concern and main reason for seeking counseling, including your reason for beginning therapy now. What goals would you like to accomplish with the help of therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I know it is my right to end therapy any time I choose to. My signature

below also indicates that all the information

I have shared is true to the best of my knowledge.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Checklist of Concerns

Please check all the items below that apply, and feel free to add any others at the bottom of the list.

❑

Abuse

—

physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals

❑

Aggression, violence

❑

Alcohol use

❑

Anger, hostility, arguing, irritability

❑

Anxiety, nervousness

❑

Attention, concentration, distractibility

❑

Career concerns, goals, and choices

❑

Childhood issues (your own childhood)

❑

Codependence

❑

Confusion

❑

Compulsions

❑

Custody of children

❑

Decision making, indecision, mixed feelings, putting off decisions

❑

Delusions (false ideas)

❑

Dependence

❑

Depression, low mood, sadness, crying

❑

Divorce, separation

❑

Drug use

—

prescription medications, over-the-counter medications, street drugs

❑

Eating problems

—

overeating, undereating, poor appetite, vomiting (circle what applies to you)

❑

Emptiness

❑

Failure

❑

Fatigue, tiredness, low energy

❑

Fears, phobias

❑

Financial or money troubles, debt, impulsive spending, low income (circle what applies to you)

❑

Friendships

❑

Gambling

❑

Grieving, mourning, deaths, losses, divorce

❑

Guilt

❑

Headaches, other kinds of pains

❑

Health, illness, medical concerns, physical problems

❑

Housework/chores

—

quality, schedules, sharing duties

❑

Inferiority feelings

❑

Interpersonal conflicts

❑

Impulsiveness, loss of control, outbursts

❑

Irresponsibility

❑

Judgment problems, risk taking

❑

Legal matters, charges, suits

❑

Loneliness

❑

Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

❑

Memory problems

❑

Menstrual problems, PMS, menopause (circle what applies to you)

❑

Mood swings

❑

Motivation, laziness

❑

Nervousness, tension

❑

Obsessions, compulsions (thoughts or actions that repeat themselves)

❑

Oversensitivity to rejection

❑

Panic or anxiety attacks

❑

Parenting, child management, single parenthood (circle what applies to you)

❑

Perfectionism

❑

Pessimism

❑

Procrastination, work inhibitions, laziness

❑

Relationship problems (with friends, with relatives, or at work)

❑

School problems

❑

Self-centeredness

❑

Self-esteem

❑

Self-neglect, poor self-care

❑

Sexual issues, dysfunctions, conflicts, desire differences, other

❑

Shyness, oversensitivity to criticism

❑

Sleep problems

—

too much, too little, insomnia, nightmares (circle what applies to you)

❑

Smoking and tobacco use

❑

Spiritual, religious, moral, ethical issues

❑

Stress, relaxation, stress management, stress disorders, tension

Suspiciousness

❑

Suicidal thought

❑

Temper problems, self-control, low frustration tolerance

❑

Thought disorganization and confusion

❑

Threats, violence

❑

Weight and diet issues

❑

Withdrawal, isolating

❑

Work problems, (circle what applies)

workaholic, can’t keep a job, dissatisfaction, low ambition)

Please write anything else that you would like me to know before our first session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_