Everlasting Solutions Counseling Services, Inc. Julia Berreth, M.A.,L.M.F.T.

Individual Intake Form

Name: ________________________ Spouse/Partner's Name: ____________________

Address: ____

Telephone/Email: Please indicate if it is O.K. to leave/send messages. Date of Birth/Age __________

Home:______________ Yes ☐ No ☐ Cell: ________________Yes ☐ No ☐

Work: ______________ Yes ☐ No ☐ E-Mail: ______________________ Yes ☐ No ☐

Occupation: ____

Education: Last Grade Completed: __________ Vocational Training ______________________

Relationship Status (check all that apply)

Married ☐ Re-Married ☐ Living Together ☐ Living Apart/Separated ☐ Divorced ☐ Widowed ☐

Single/Never Married ☐ Significant Other ☐

Children (include biological, adopted, foster, step, etc.):

Name	Sex	Age	Type(bio, step, etc.)	Custody?
____________	___	___	____________	Yes ☐ No☐
____________	___	___	____________	Yes ☐ No ☐
____________	___	___	____________	Yes ☐ No ☐
____________	___	___	____________	Yes ☐ No ☐

Family of Origin Information:

Who did you grow up with? ____

Parents married Yes ☐ No ☐ Divorced Yes ☐ No ☐ When? ______ Never Married Yes ☐ No ☐

Are your parents deceased? Yes ☐ No ☐ Father? ☐ Mother? ☐ Cause of death?____________

Siblings: (Name, Age, Place of Residence, Spouse/partner, Number of children)

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____

How would you describe your family of origin and your experiences while growing up?

____

____

____

How would you describe the status of your current relationships both within your own family and family of origin?

____

____

____

Are you presently under a physicians care? Yes☐ No ☐ If yes for what? _________________________

List any medications and amounts: ____

Name/Phone/Address of Physician ____

Have you ever been hospitalized for a psychiatric illness? Yes ☐ No ☐ If yes for what?

____

Any one in your family been diagnosed with a psychiatric condition? Yes ☐ No ☐ If yes for what?

____

Have you ever had previous counseling and/or psychological help? Yes☐ No ☐

Check all that apply:

Individual Counseling ☐Couples Counseling ☐ Group Counseling ☐ Family Counseling

If yes, when and where did you receive counseling and what were the issues?

____

____

What do you hope to accomplish through counseling?

____

____

What have you already done to deal with the difficulties?

____

____

What are your biggest strengths? What do you do for fun/to relax?

____

____

Do you consume alcohol? Yes ☐ No ☐ How many per week? ____________

Do you use non-prescribed drugs? Yes☐ No ☐ Type: ___________ How often? ____________________

Please check all that apply and if either past or present difficulty or both.

	PAST	PRESENT
Problem/Difficulty		
Physical Problems		
Substance Use/Abuse/Addictions		
Sexual Abuse		
Thoughts/Behaviors of harming self or others		
Irregular Eating Habits		
Sleep Problems		
Performance at School		
Performance at Work		
Making Friends		
Understanding Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to have a good time		
Feel cut off from others		
Communication Problems		
Sexual Problems		
Financial Problems		
Specific Fears:		
Can’t stop thinking about:		
Feeling Depressed		
Feeling Inferior		
Emotionally Numb		
Lack of Confidence		
Excessive Worry		
Can’t Make Decisions		
Don’t like Week-Ends or Vacations		
Forgetfulness		
Lack of Goals		
Unable to Cope with Day to Day life		
Afraid of being on My Own		
Suicidal Thoughts/Behaviors		
Feeling Tense/Anxious		
Feeling Angry		
Can’t sit still		
Over-ambitious		
Seeing or hearing things		
Nightmares		

Were you referred? Yes ☐ No ☐ By Whom? ____

If you were not referred how did you find this counseling service? _______________________________

Person to contact in case of emergency:

Name: ____

Address: ____

Phone: ____

IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.

A Counseling Session is normally **50** minutes. If longer sessions are desired please discuss this with your therapist. Fees increase with longer sessions.

A 24-HOUR CANCELLATION NOTICE IS APPRECIATED, OTHERWISE A FEE WILL BE CHARGED.

Form completed by:

Signature____ Date _________________________

Printed signature ____