Rowan-Bailey Counseling, LLC, 1246 S. Fort St., #250, Draper, UT 84020

Client Intake

Name: ____ Date: ____________________

Address/City/Zip: ____ Phone: ___________________

Birth date: ________________ Age: _______ Email: ____________________

Please describe the problem(s) that you want help with: ____

____

____

How has this problem affected your life in the following areas?

1. Family ____
2. Work ____
3. Social ____
4. Recreational ____
5. Health ____

How long have you had this problem? ______________________

Please list any important events in your life that may relate to this problem:

____

____

____

How serious is this problem to your daily functioning? mildly moderately extremely

What have you tried to solve this problem? ____

____

What has been successful? ____

____

Have you had counseling/therapy in the past? Yes No

If so, where? _ ____ When? ___________________________

What was helpful about the counseling?____

What was not helpful about the counseling? ____

MARITAL STATUS:

- ☐ Single
- ☐ Married: How Long? ___________
- ☐ Separated: How long? ___________
- ☐ Previously married: How many times? ____
- ☐ Living with someone: How long? _______
- ☐ Widowed -- How long? ____________

FAMILY HISTORY:

Who were your primary caregivers? ____

If there were changes, please list and indicate the age you were when these changes occurred:

____

____

# of siblings ________ # brothers _____ # sisters _____

In rank order from oldest to youngest, what is your place in the birth order? ____________________________

Which members of your family are you close to? ____

____

Are there any family members who are a problem for you? ____

____

Please indicate other people in your life that provide support for you:

____

Please check any problems that family members have/have had and indicate relationship to you:

- ☐ Arrests/convictions ______________________________
- ☐ Alcoholism ______________________________
- ☐ Depression ______________________________
- ☐ Violence ______________________________
- ☐ Other mental/emotional problems ____

Check any of the following that apply to your childhood/adolescence:

- ☐ Happy childhood
- ☐ School problems
- ☐ Medical problems
- ☐ Unhappy childhood
- ☐ Family problems
- ☐ Alcohol use/abuse
- ☐ Drug use/abuse
- ☐ Arrests/convictions

Victim of:

- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Bullying

SPIRITUAL PREFERENCE

What religion do you practice, if any? _____________________________ For how long? ____________

EDUCATIONAL HISTORY:

Grade or degree completed ______________________________

Problems: ____

Strengths: ____

WORK HISTORY:

Current occupation: ____

Are you currently employed: Yes No Length of time: _______________________________________

If you have changed jobs during the last five years, give duration of employment and reason for leaving job:

____

____

Are you satisfied with and/or enjoy your current work situation? Yes No Why or why not? _______

____

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health? Very poor 1 2 3 4 5 6 7 8 9 10 Very good

List current health problems for which you are receiving treatment: ___________________________________

____

List any medications currently prescribed: ____

What is your current use of alcohol? ____

Have you had problems with alcohol use in the past? Yes No

If yes, please explain: ____

What is your current use of other drugs? ____

Do you have a history of drug use?	Yes	No
Have you been arrested for alcohol/drug related offenses?	Yes	No
Have you had treatment for problems with alcohol/drug abuse/dependency?	Yes	No
Have you ever lost a job/relationship due to the use of alcohol/drugs?	Yes	No

Indicate any of the following that apply to you currently or in the past:

- ☐ Thoughts of suicide
- ☐ Plan for suicide
- ☐ Suicide attempt
- ☐ Self-harm (Cutting, burning, mutilation)
- ☐ Thoughts of hurting someone else

SEVERITY OF PROBLEM: 0=NO PROBLEM 5=DISABLING	**INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:**
0 1 2 3 4 5	Sleep too much
0 1 2 3 4 5	Sleep too little, Interrupted sleep
0 1 2 3 4 5	Memory
0 1 2 3 4 5	Concentration, Attention
0 1 2 3 4 5	Loss of interest in usual activities
0 1 2 3 4 5	Feelings of sadness
0 1 2 3 4 5	Loss of energy, Feeling tired most the time
0 1 2 3 4 5	Periods of crying
0 1 2 3 4 5	Feeling of hopelessness or helplessness
0 1 2 3 4 5	Loss of sexual desire
0 1 2 3 4 5	Outbursts of anger
0 1 2 3 4 5	Change in appetite
0 1 2 3 4 5	Hearing voices when no person is present
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5
0 1 2 3 4 5	Unable to recall some period of your day
0 1 2 3 4 5	Nightmares
0 1 2 3 4 5	Overwhelming fears
0 1 2 3 4 5	Racing thoughts
0 1 2 3 4 5	Thoughts that won't go away that are constantly in your head
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Excessive sweating
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Other: