Transformative
Counseling & Family Services

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Today's Date ____________

Patient Intake

Patient Last Name		Patient First Name	**Date of Birth**
Address		City, Sate, Zip	
Guardian (First & Last name)		Patient SSN#	
Home Phone#	Cell #	Email	

Gender Identity: (circle one)

Male Female Transgender Androgynous Questioning Other __________________

Sexual Identity: (circle one)

Heterosexual Homosexual Bisexual Questioning Other ___________________

Ethnic Identity: ____

Religious Identity: ____

Physical Health (disabilities, allergies, chronic pain or illness): ___________________________________

Occupation: ____

Current household

Name	Age	Gender	Relationship

Reason(s) for seeking counseling: ____

____

History of issue: (when started, how, frequency) ____

____

Recent Losses or grief: ____

Client strengths: ____

____

Abuse History

Has client experienced any of the following, if so, please explain:

Physical harm	Yes or No	
Neglect	Yes or No	
Sexual assault or Inappropriate contact	Yes or No	
Verbal or Emotional abuse	Yes or No	
Exposure to domestic violence	Yes or No	
Dating violence	Yes or No	
Bullying	Yes or No	
Sexual acting out or offense	Yes or No	
Other:		

For Children

Developmental Delays: (pregnancy, delivery, infancy) please explain below:

School: ____

Grade: ____________________

Attendance: (circle one) Attending Regularly Attending Irregularly Current Becca Petition

IEP or 504 Plan: Yes No

Academic concerns (grades, suspension, expulsions) please explain below:____

CPS involvement

Current or past please explain:

When: ____

Reason: ____

____

Legal issues

Juvenile, custody, criminal past or current, please explain:

Type: ____

When: ____

Reason: ____

____

History of Mental Health

Family members with mental illness (relationship and diagnosis)

____

Previous counseling (when and where, name of therapist, diagnosis): _____________________________

____

Hospitalizations (reason, where and when): ____

____

Suicidal thoughts or attempts (when, history of attempt): _____________________________________

____

Self-harm (method, frequency): ____

Drug & Alcohol

Substance (list)	Frequency of Use (How often)	Treated (Yes or No)

If treated, please explain: when, where and outcome: ____

____

Current Medications

Name	Dosage	Purpose

Psycho/Social/Behavioral Symptoms

Past or current, occurrence, frequency, please specify (check all that apply)

	Past or Current	Frequency in a week or month	Explain:
Eating too much or too little			
Sleeping too much or too little			
Attention seeking behavior			
Anger			
Fighting			
Cruelty to others			
Cruelty to animals			
Destruction of property			
Lying			
Stealing			
Running Away			
Impulsivity			
Fidgeting			
Interrupting			
Easily Overwhelmed			
Excessive worry or tension			
Loss of interests			
Panic Attacks			
Repetitive or Compulsive behaviors			
Withdrawn			
Excessive gaming			
Gambling			
Unaccounted for money items Or goods			
Provocative clothing			
Change in language, name or nickname			
Other Concerning behaviors			
Repetitive and or Compulsive Behaviors			