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): _____

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			