

Holman Family Services

COUNSELING INTAKE

Welcome to Holman Family Services. Please answer all questions as completely as possible. The information you provide is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Please show your Photo ID to your therapist

Client Name: _____
Last First MI AGE/DOB SEX: M/F

Home Address: _____
Street City State Zip

Please list the **BEST** Contact Phone Number you (the client) would like for us to use. If the Client is a minor please list the Parent/ legal guardian's info.

BEST Phone: _____ **Is this your Home, Work or Cell? (Please circle)**
May call: Yes No Message: Yes No Texts: Yes No

Alternate Phone: _____ **Is this your Home, Work or Cell? (Please circle)**
May call: Yes No Message: Yes No Texts: Yes No

Email Address: _____ Email Address: _____

For Appointment Reminders via Text please provide the clients Cell Phone Carrier: _____

Clients Emergency Contact:

Name of Clients Spouse: _____
Last First MI AGE: SEX: M/F

**If the client is a Minor please provide the Name(s) of Parent(s)/ Legal Guardian(s):

Mother's First, Last Name Fathers First, Last Name

In case of emergency, contact: _____
Name: First, Last Relationship BEST Contact Phone

Clients Spirituality: (optional)

Denominational Preference: _____ Church Membership: Yes or No

Name of Church: _____ Pastor's Name: _____

Have you (the client) accepted Jesus Christ as your Lord and Savior? _____ Have you (the client) had any recent changes in your religious belief? _____ If so, what was the change? _____

Client Other Info:

What is your (the clients) ethnicity?

- African American Bi-racial Hispanic/Latin
 Asian Caucasian Native American Other _____

What is your (the clients) Educational Level?

- 8th grade or below Trade School Master's Degree High School
 Ph. D. Degree GED College Graduate Some College

How were you (the client) referred to our center? (Check those that apply):

- Employer Mandated Court Minister Other Physician
 Friend or Co-Worker Relative Counselor/Psychologist/Psychiatrist Radio Station

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Have you (the client) ever seen a mental health professional before? (Psychiatrist, psychologist, or a therapist/counselor)?

Yes No If yes, please provide their contact info below.

Previous Spiritual/Mental Health Professional/Agency _____
Name Address

Phone _____ Fax _____ Dates of Service (beginning - ending) _____

Are there currently any other family members of the clients that are receiving services at this center?

Yes No (If yes what are the Name/Dates of service?)

First Name _____ Last Name _____ Dates of service Month/Year _____

Are you (the client) seeking services because they are a victim of a crime? Yes No

If yes, Did it result in legal action? Yes No

Have you (the client) ever been hospitalized for spiritual/mental health concerns: Yes No

If yes, please explain: _____

Are you (the client) currently involved in a custody dispute? Yes No (If yes, please explain)

Are you (the client) currently on mandatory court ordered therapy? Yes No (If yes, please explain)

Are you (the client) currently on probation? Yes No

Are you (the client) currently on mandatory CPS court ordered therapy or investigation? Yes No (If yes, please explain)

Tell us about your (the clients) current living arrangements:

- | | | |
|---|--|---|
| <input type="checkbox"/> Family of origin/ birth family | <input type="checkbox"/> Relatives | <input type="checkbox"/> Single |
| <input type="checkbox"/> Married | <input type="checkbox"/> Roommates(s) | <input type="checkbox"/> Single parent w/children |
| <input type="checkbox"/> Married w/children | <input type="checkbox"/> Significant other | <input type="checkbox"/> Other _____ |

Tell us about your (the clients) CURRENT family

Directions: Please list who lives in your home currently; *If you (the client) are married with children, then please list your family beginning with the oldest member and include yourself.*

Name _____ Age/DOB _____ Gender _____ Relationship to you (include step, half, etc.) _____

Name _____ Age/DOB _____ Gender _____ Relationship to you (include step, half, etc.) _____

Name _____ Age/DOB _____ Gender _____ Relationship to you (include step, half, etc.) _____

Name _____ Age/DOB _____ Gender _____ Relationship to you (include step, half, etc.) _____

Name _____ Age/DOB _____ Gender _____ Relationship to you (include step, half, etc.) _____

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CURRENT FAMILY

Family Atmosphere

Directions: Please circle the number that best describes how you (the client) view your **current** family

Very lenient	<u>1</u>	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Directions: Please circle the number that best describes how much support you (the client) feel that you receive.

Hardly any support 1 2 3 4 5 Considerable support

FAMILY OF ORIGIN (PAST HISTORY)

Family Atmosphere

Directions: Please circle the number that best describes how you (the client) view your family that you grew up with

Very lenient	<u>1</u>	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Directions: Please circle the number that best describes how much support you (the client) feel that you receive.

Hardly any support 1 2 3 4 5 Considerable support

Please tell us why you (the client) came to counseling

Directions: Indicate severity by checking either:

1=mild (very little problem); 2= moderate (some problem); or 3= sever (very serious problem).

Please be sure to check the item(s) that you (the client) see as the most significant issue.

Abuse (physical, emotional, sexual)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Career Dissatisfaction or decisions

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Disturbing memories (past abuse, neglect or other traumatic experience)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Drug or alcohol use (both legal and illegal drugs)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my(the clients) life

Family or Step-family relationship

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1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Feeling angry or irritable

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Feeling guilty or shameful

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Feeling sadness or depression or suicidal urges NOT related to grief

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Feeling sadness or depression or suicidal urges related to grief

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Health concerns (physical complaints and/or medical problems)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Illegal behaviors (repeated run-ins with the law, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Learning/Academic difficulties

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Parent-Child relationship (discipline, adoption, single parent, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Personal Growth (no specific problem)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Religious or Spiritual concerns

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Sexual functioning concerns

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Sexual identity concern

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Significant other/spouse relationship

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1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Sleep problem

(Nightmares, sleeping too much or too little, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Speech problem (not talking, stuttering, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Unusual experiences (loss of periods of time, sensing unreal things, etc.)

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

Other: Please Explain

1-mild; 2-moderate; 3-severe

Most Significant Issue

No Concerns with this issue in my (the clients) life

When did you (the client) first become concerned about this/these issue(s)? _____

If the client is a minor; when did the legal guardian of the client first become concerned about this issue? _____

Did you (the client) attempt to resolve or get assistance with any of the issues you indicated above? If yes, please check how you attempted to resolve or receive assistance with them.

Couples Counseling

Family counseling

Talked with friends

Talked with parents

Group counseling

Hospitalization

Talked with minister

None of the above

Individual counseling

Other _____

Is there anything else you feel your therapist should know? If so, please use the space below to explain.