



Transformative  
Counseling & Family Services

18537 1<sup>st</sup> Ave S. Suite B  
Normandy Park, WA 98148  
P:425-390-4677  
F:206-858-9754  
TransformativeCFS.com

Today's Date \_\_\_\_\_

**Patient Intake**

Patient Last Name		Patient First Name		Date of Birth
Address		City, State, 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			
Changes in mood			
Excessive gaming			
Gambling			
Unaccounted for money items Or goods			
Provocative clothing			
Change in language, name or nickname			
Other Concerning behaviors			

DX: \_\_\_\_\_

\_\_\_\_\_