COUNSELING CENTER FOR WOMEN

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Associate Licensed Counselor

of Martha B. Ellis

334-207-9400

CONFIDENTIAL INTAKE INFORMATION

General Information **Date_____**

Client's Last Name: _____ First Name: _____ MI: _____

Age: _____ Date of Birth:_____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Ok to leave voicemail: yes no

Home Phone: _____ Ok to leave voicemail: yes no

Work Phone: _____ Ok to leave voicemail: yes no

Email: _____

Authorization is granted to send email: yes no

Employment

Current Employer: _____ Length of time employed: _____

If currently unemployed, how long?_____

Have you ever served in the military?___ If yes, please list branch, rank, and current status (active/ discharged/retired)_____

If deployed, please list dates: _____

Educational/Training Background

High School Diploma		**GED**		**Vocational/Trade School Certificate**		**Associates Degree**	
Bachelors Degree		**Masters Degree**		**Doctorate Degree**		**Other**	

Major or name of program: _____

Emergency Contact Person _____ *Address* _____ *Phone #* _____

Family Information

Are you currently in a relationship? yes no If yes, please list status:_____

Name of person: _____ Length of time together_____

Number of marriages:____Number of divorces:____ If widowed, your age at death of spouse: _____

Do you have children? If yes, please list below:

Name	Age	Lives with you? Yes/No	Name	Age	Lives with you? Yes/No

Other persons living in your household and your relationship to them:

_____

Medical History

Name of Primary Physician_____Phone#_____

Please list any prescription medications you are currently taking.

Medication(s)	Dosage	Medication	Dosage

Please list any over the counter medications, vitamins, or herbal supplements you are using:

_____

Physical Health Information

Please answer the following questions using:

5- Excellent, 4- Good, 3- Average, 2- Poor, 1- Failing

How would you currently rate your physical health:_____

How would you currently rate your mental health:_____

How would you rate your spiritual health:_____ (If does not apply, please use N/A)

Medical Health Information

Do you now have, or have you had in the past, any of the following? Check all that apply. ***(Please enter date of onset inside the box that applies.)***

	Asthma		**Allergies**		**Heart Disease**		**Arthritis**		**Headaches**
	Fibromyalgia		**Sleep Disorder**		**Tuberculosis**		**High Blood Pressure**		**Immune System Problems**
	Epilepsy		**Brain Injury**		**Vision Problems**		**Hearing Problems**		**Sexually Transmitted Disease**
	Seizures		**Diabetes**		**Cancer**		**Chronic Fatigue Syn.**		**Breathing Problems**
	Multiple Sclerosis		**Thyroid Disorder**		**Urinary Disorder**		**Digestive Disorders**		**Blood Disorders**
	Weight loss		**Surgery**		**Miscarriage (# ___)**		**Abortion (# ___)**		**Pregnancy (# ___)**

___Other illnesses: Please explain _____

Please indicate substances currently used (over the past six months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Caffeine						
Alcohol						
Diet Pills						
Tobacco						
Marijuana						
Ecstasy						
Street Drugs						
Cocaine/Crack						
Heroin						
Meth						
PCP/LSD						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						

Have you ever believed your substance use was a problem?_____

Has anyone ever told you your substance use was a problem?_____

Have you ever had withdrawal symptoms when trying to stop using?_____

Have you ever had problems with work, relationships, or the law due to your substance use? _____If yes, please describe:_____

Have you ever participated in drug and/or alcohol treatment?_____

If yes, please list type, length, dates and age at time of services._____

_____

Do you currently or have you participated in Alcoholics or Narcotics Anonymous?_____

If yes, please list length of time sober and number of meetings you attend per week._____

<u>Mental Health Information</u>

Please check any of the following symptoms or complaints that apply to your situation:

	Sad Mood		Low Energy/ chronic fatigue		Hopelessness		Worthlessness		Guilt
	Crying Spells How many times a day/week/ month?		Decreased motivation/apathy (I don't care attitude)		Loss of interest in usual activities What activities?		Loss of concentration and/or memory difficulties		Irritability
	Hyperactivity		Impulsiveness		Increased sexual interests		Loss, decrease, or increase of appetite		Social isolation/ withdrawal
	Difficulty staying asleep/falling asleep		Excessive sleeping		Early morning awakenings		Racing thoughts		Elevated mood
	Excessive Worrying or feeling anxious		Panic Attacks What symptoms?		Fear of situations or things? What situations or things?		Fear of leaving home		Fear of embarrassing oneself in public
	Intruding or repetitive uncomfortable/ upsetting thoughts		Being orderly or a perfectionist,		Rebelliousness or defiant behaviors		Excessive anger or aggressiveness		Spitefulness or vindictiveness
	Difficulty trusting others		Binging/purging, or restricting food		Victim of physical abuse		Victim of sexual abuse		Victim of emotional abuse

Add any necessary comments about items checked above:

Symptom:_____Comment:_____

Symptom:_____Comment:_____

Symptom:_____Comment:_____

Symptom:_____Comment:_____

Symptom:_____Comment:_____

Symptom:_____Comment:_____

Have you ever or are you currently engaging in self-harm? Currently:____Past____

Have you ever or are you currently contemplating harming another person? Currently____Past____

Have you ever or are you currently contemplating suicide? Currently:____Past____

Have you ever attempted suicide?____ If yes, please list date(s), method(s), and your age at the time of attempt._____

_____

Has anyone in your family ever attempted suicide? ____ If yes, please list relationship _____

Has anyone in your family ever completed suicide? ____ If yes, please list relationship _____

Are you currently receiving mental health services? ___ If yes, please list name and address of practitioner and type of services:

_____

Have you ever been diagnosed with a mental illness? ___ If yes, please list illness(es) and date(s) first diagnosed:_____

_____

Have you ever been hospitalized for a mental health concerns? ___ If yes, list dates and length of stay._____

Date of Most Recent Illness/Symptom or issue for which you are seeking counseling:

_____

Have you previously had the same or similar symptom(s)? Yes____ No____

If yes, give first date: _____

If unable to return to work, give date:_____

Hospitalization Dates Due to Current Illness/Symptoms:_____

Is Current Condition Due to any of the following?

Auto Accident yes ____ no____ Other Accident yes ____ no____ Employment yes ____ no____

Client's Family History Information

Did your parents ever divorce? _____ If yes, your age at time of divorce: _____

With whom did you live until the age of 18?_____

Were you adopted? _____ If yes, at what age_____

Were you ever in foster care or residential care? _____ If yes, please list age and living situation:_____

Mother's current age:____If deceased, her age at death:____Your age upon her death:___

Father's current age:____ If deceased, his age at death: ____Your age upon his death:____

Do you have siblings?____If yes, please list names, ages, and relationship:

Name	**Age**	**Relationship (biological, half, step)**

Client's Family Mental Health Background

Is there any history of the following in the client's family? (Family includes parents, siblings, paternal or maternal grandparents, aunts, uncles, and/or cousins)

Depression Yes ____ No____ Family Member(s) with Condition_____

Anxiety Yes ____ No____ Family Member(s) with Condition_____

Bi-polar Yes ____ No____ Family Member(s) with Condition_____

Schizophrenia Yes ____ No____ Family Member(s) with Condition_____

Drug Abuse Yes ____ No____ Family Member(s) with Condition_____

Alcoholism Yes ____ No____ Family Member(s) with Condition_____

Other Yes ____ No____ Family Member(s) with Condition_____

Please indicate if a member of your immediate family experienced any of the following:

	Emotional Abuse		**Legal Problems**
	Physical Abuse		**Frequent/Multiple Moves**
	Sexual Abuse		**Homelessness**
	Domestic Violence		**Financial Problems**
	Neglect		**Lived over-seas**
	Military Member		**Serious Illness**
	Accident or Injury		**Other**

Legal Information

Have you ever been the victim of a crime? ____ If yes, please list date and briefly describe:_____

Are you currently involved in a divorce or child custody proceedings?____ If yes, please explain:_____

Have you ever been convicted of a misdemeanor or felony? ____ If yes, please explain:_____

Are you currently involved in any legal actions? If so, please explain_____

_____

Is there a recent life crisis that has prompted you to seek counseling at this time?

___yes no___ If so, please describe_____

_____

I further acknowledge that I am voluntarily consenting to counseling and that no guarantees have been made as to the results of counseling.

Signature_____ Date_____

Revised 2014