FORTE COUNSELING GROUP

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CLIENT INTAKE FORM

Legal Name: _____ ☐ Male ☐ Female ☐ Other

Name you prefer: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ ☐ Ok to leave message

Cell Phone: _____ ☐ Ok to leave message

Preferred method of contact: ☐ Phone call ☐ Text messaging ☐ email

Would you like email reminders of your appointment? ☐ Yes ☐ No Email address (if yes) _____

Would you like text reminders of your appointment? ☐ Yes ☐ No

Relationship status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

How long with current partner? _____ Living together? ☐ Yes ☐ No

Children: Names and ages _____

Emergency contact: _____ Phone: _____ Relationship: _____

Referred by (please check all that apply): ☐ Good Therapy ☐ Psychology Today ☐ Portland Therapy Center

☐ Online search directly led me to your website ☐ Word of mouth
(name of the person who referred you) _____

☐ Other _____

Your answers to the questions below will provide additional information that will be beneficial to our counseling sessions. Please answer the questions below as completely as is comfortable for you. All answers will be kept confidential.

About counseling...

Briefly describe the problem that brings you to counseling: _____

_____

_____

What have you done to try and resolve this problem? _____

After counseling, what do you hope will be different regarding this problem? _____

What previous experience do you have with counseling? _____

Please mark any of the following that you are currently experiencing:

- ☐ Aggression/Fights
- ☐ Anxiety/Worry
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Compulsive Behavior
- ☐ Computer Addiction
- ☐ Crying Spells
- ☐ Depression/Sadness
- ☐ Distractibility
- ☐ Eating Problems
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Fear Away from Home
- ☐ Flashbacks
- ☐ Frequent Arguments
- ☐ Gambling Problems
- ☐ Guilt/Shame
- ☐ Hallucinations
- ☐ Hearing voices
- ☐ Hoarding
- ☐ Homicidal Thoughts
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Increasing alcohol/Drug Use
- ☐ Impulsivity
- ☐ Irritability/Anger
- ☐ Lack of Motivation
- ☐ Libido Changes
- ☐ Loneliness
- ☐ Loss of Pleasure/Interest
- ☐ Low self worth
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Parenting Problems
- ☐ Poor memory/Confusion
- ☐ Problems with Pornography
- ☐ Racing Thoughts
- ☐ Relationship Problems
- ☐ Risky Activity
- ☐ Self-harm Behaviors
- ☐ Sexual problems
- ☐ Shopping Addiction
- ☐ Social discomfort
- ☐ Sleep Changes/Problems
- ☐ Suspicion/Paranoia
- ☐ Withdrawal from people
- ☐ Work/school problems

Other:_____

Are you currently experiencing suicidal thoughts? ☐ No ☐ Yes If yes, please describe: _____

Have you experienced suicidal thoughts in the past? ☐ No ☐ Yes If yes, please explain:_____

Have you ever attempted suicide? ☐ No ☐ Yes If yes, when _____

If yes, please describe the attempt: _____

Are you or anyone in your household currently experiencing abuse or violence of any kind? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

Present Situation

How would you describe your current intimate relationship (if any): _____

_____

Are you divorced? If yes, specify year of divorce: _____

Prior marriages? If yes, how many? _____

Do you have child(ren)? If yes, how is your relationship with your child(ren):_____

_____

Briefly tell me about your network of social support (friends, co-workers, neighbors, religious/spiritual, self-help/support groups, etc.) _____

_____

_____

Do you feel you have an adequate support system? ☐ No ☐ Yes

Medical History

How would you describe your physical health? _____

_____

Are you currently being treated for any medical conditions? ☐ Yes ☐ No Please explain _____

_____

Are you currently taking any medication for mental health or medical condition? ☐ Yes ☐ No

Medication: _____ Dosage: _____ per/_____

Medication: _____ Dosage: _____ per/_____

Medication: _____ Dosage: _____ per/_____

What was your previous mental health diagnosis (if applicable) _____

Have you ever tried the following? (check all that apply)

- ☐ Alcohol
- ☐ Cocaine
- ☐ Ecstasy
- ☐ Hallucinogens
- ☐ Heroin
- ☐ Marijuana
- ☐ Methadone
- ☐ Methamphetamines
- ☐ Pain Killers
- ☐ Stimulants
- ☐ Tobacco
- ☐ Tranquilizers

Other _____

If yes to any, list frequency and dates of last use: _____

_____

Have you ever been treated for drug/alcohol abuse? If yes, when? _____

_____

Have you ever abused prescription drugs? If yes, which ones? _____

_____

Family history.... In a few words, describe what your relationship has been like with your:

Mother:_____

_____

Father:_____

_____

Siblings (include ages): _____

_____

Other significant family members: _____

_____

Before you were 18, did you experience any of the following?:

- ☐ Parents divorced (your age _____)
- ☐ Adopted (your age _____)
- ☐ Lived with step-parent or step-siblings
- ☐ Raised by someone other than parent (Who? _____)
- ☐ Other _____

Have you experienced the death of someone close to you? Please give the name and relationship of the person(s) and when they died (or your age at the time):_____

Did either of your parents abuse alcohol or other drugs?_____

Were the adults in your household abusive or disrespectful to each other? _____

_____

Were you verbally, emotionally, sexually or physically abused? _____

_____

Do any of your current or extended family members have a history of mental illness (depression, anxiety, attention deficit disorder, addictions, etc.)? _____

_____

Has anyone close to you committed suicide or attempted to commit suicide? _____

_____

Is there anything that troubles you about your childhood (family, school, social, etc.)? _____

_____

Other...

Is there anything else you feel is important for your counselor to know_____

_____

Thank you for taking the time to answer these questions.