Beloit Health System
COUNSELING CARE CENTER
INITIAL INTAKE ASSESSMENT

Legal Name____________________________ Medical Record Number ____________________

Preferred Name ____________________________ Personal Pronouns ____________________

Therapist ____________________________ Today's Date (Intake) ____________________

Date of Birth __________________Age ______ Home/Cell Phone ____________________

Address ____________________________ City ____________ State ______ Zip _______

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other ____________________

Present Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating ☐ Domestic Partnership/Civil Union ☐ Unmarried Partner ☐ Other ____________

Length of current marriage/relationship: ____________________________

Assessment of current relationship if applicable: ☐ Poor ☐ Fair ☐ Good

How many times have you been married? ____________________________

How would you describe your cultural identity? ☐ African American ☐ Caucasian/White ☐ Asian American ☐ Native American ☐ Hispanic ☐ Biracial ______________ ☐ Other ________

Referred by: ☐ Self ☐ Dr. ______________ ☐ Other ____________________

Briefly describe the problem for which you are seeking to have counseling for? ____________________

____

What would you like to see happen as a result of counseling? ____________________________

____

Which of the following concerns do you have?

Suicidal Thoughts &/or Attempts	☐	Self Injury Behaviors	☐
Homicidal Thoughts &/or Behaviors	☐	Troubling Thoughts/Urges/Habits	☐
Anger outbursts/ Aggressive behaviors	☐	Poor Academic Performance	☐
Learning difficulties	☐	Parenting Issues	☐
Attention and concentration difficulties	☐	Physical Health/Pain	☐
Hyperactivity	☐	Traumatic Experience/s	☐
Anxiety/ Nervousness	☐	Fears	☐
Victim of Abuse/Neglect	☐	Low Self-Esteem	☐
Fatigue/Low Energy	☐	Mood Swings	☐
Depression/sadness	☐	Social Isolation	☐
Feeling Hopeless/Worthless	☐	Unstable/Excited moods	☐
Obsessive thinking/behaviors	☐	Hallucinations/Delusions	☐
Motor Coordination	☐	Repetitive Behaviors/ Movements	☐
Relationship problems	☐	Alcohol/drug Use	☐
Seizures	☐	Eating habits/nutrition/problems	☐
Grief/Loss Issues	☐	Medication Problems	☐
Nightmares/ Night Terrors	☐	Problems with Hearing/Vision	☐
Problems Falling Asleep	☐	Problems Staying asleep	☐
Other __________________	☐		

Please rate how intense the issues are, that bring you/your child to the Counseling Care Center today.

0 1 2 3 4 5 6 7 8 9 10

Not At All Overwhelming

MARITAL AND FAMILY INFORMATION

Please list all members in your present household:

Name	Relationship	Age	Employment/School Status

Please describe any problems or concerns about family issues/conflicts (i.e., emotional, behavioral, legal, alcohol or drug use, etc.) ____

____

Please describe strengths and/or supports in your family or friends ____

____

FAMILY OF ORIGIN

How would you describe your family life growing up? ____

____

Please describe any significant childhood/adolescent or young adult issues that are still affecting you today: ___________

____

Did you have any of the following problems growing up?

☐ Physical developmental problem – please describe ____

☐ Learning difficulty/disability – please describe ____

☐ Emotional/Behavioral problems/disability – please describe ____

EDUCATION / VOCATION

Please check all those that apply to you:

☐ Housing concerns ☐ Limited social supports ☐ Financial concerns ☐ Other ____________________

What are your strengths? ____

What personal qualities would others say you have?____

What is your highest level of education completed? ☐ Grade School ☐ GED

☐ High School – highest grade completed _____ ☐ Some College ☐ Associate's Degree

☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

What was your emphasis of study? ______________________________

Did you serve in the military? ☐ Yes ☐ No Branch: ______________ Rank ______________

Dates of Service ______________________ Where ______________________

Please describe your experience ______________________________

What is your present employment status? ☐ Full Time ☐ Part Time ☐ Disability

☐ Homemaker ☐ Retired ☐ Unemployed

Where do/did you work (most recent job)? ______________ What is/was your job title? ______________

How would you describe your job experiences? ______________________________

LEISURE ACTIVITES

Please list any of your current interest, hobbies, community or recreational activities: ______________

____

Has there been a change in your involvement in these activities lately? ☐ No ☐ Yes

☐ Increase ☐ Decrease ☐ Gave Up

LEGAL STATUS

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past: ______________________________

____

PSYCHIATRIC INFORMATION

Please list previous **OUTPATIENT** mental health/counseling or alcohol/drug/addiction services:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please list previous **INPATIENT** mental health services or alcohol/drug/addiction inpatient treatment:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please describe any mental health concerns in your family ______________________________

MEDICAL INFORMATION

Who is your current physician(s)? ____

When was your most recent physical exam? ______________________________________

Please list any allergies including food, pollens and medications ___________________________

Please list any current medications/over the counter medications/vitamins/natural remedies ______________

____

CURRENT medical or dental health concerns _____________________________________

What is your current pain level?

0	1	2	3	4	5	6	7	8	9	10
None										Unbearable

Where is the pain located in your body? ____

PAST medical health concerns ____

Is there a history of any of the following in you or your family?

- ☐ Tuberculosis
- ☐ Birth Defects
- ☐ Emotional Problems
- ☐ Behavior Problems
- ☐ Thyroid Problems
- ☐ Cognitive Disabilities
- ☐ Heart Disease
- ☐ Obesity
- ☐ Stroke
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Asthma
- ☐ Cirrhosis
- ☐ Multiple Sclerosis
- ☐ Huntington's Disease
- ☐ Parkinson's Disease
- ☐ High Blood Pressure
- ☐ Ulcers/Colitis
- ☐ Cancer Type____________________________
- ☐ Alzheimer's disease/dementia
- ☐ Auto-Immune Disease- Lupus
- ☐ Other: Please Describe: ____

SUBSTANCE USE/ABUSE HISTORY

Has anyone expressed concern about your use of alcohol or drug use? ☐ Yes ☐ No

Are you concerned about your use of alcohol or drug use? ☐ Yes ☐ No If Yes:

Has your tolerance increased over time? Please explain ______________________________

Have you experienced work problems related to use? Please explain ____________________

Relationship problems related to use? Please explain ________________________________

How often do you drink to intoxication per month? Please explain _____________________

Do you experience cravings and/or withdrawal symptoms? Please explain _______________

Family history of use? Please describe ____

____

RELIGION/SPIRITUALITY

Do you consider yourself a spiritual/religious person? ☐ Believe in God ☐ Believe in a Higher Power

☐ Non-believer ☐ Unsure ☐ Other ________________________________

Do you feel this has an impact on your therapy? ☐ No ☐ Yes, Please explain ____________________

Please describe any thoughts, feelings, plans or attempts you are experiencing/have experienced to hurt yourself, kill yourself or hurt others: ____