Beloit Health System
COUNSELING CARE CENTER
INITIAL INTAKE ASSESSMENT

Name_____ Medical Record Number _____

Therapist _____ Today's Date (Intake) _____

Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Gender: ☐ Male ☐ Female ☐ _____

Present Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabitating

☐ Civil Union ☐ Domestic Partnership ☐ 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 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: _____

_____