Parent Completed Psychosocial Intake Form

GENERAL INFORMATION

Date: _____ Referred By: _____

Full Name of Client: ☐ Mr. ☐ Miss_____

Name Client Prefers: _____ Age: _____ Date of Birth: _____

Client Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other: _____ Sex: ☐ Male ☐ Female

Your Name (Person Completing this for Minor Client): _____

Your Relationship to Client: _____

CLIENT CONTACT INFORMATION

Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Phone: _____ May we leave a message here: ☐ Yes ☐ No

Mobile Phone: _____ May we leave a message here: ☐ Yes ☐ No

Client Email Address: _____ May we leave a message here: ☐ Yes ☐ No

Your Mobile Phone: _____ May we leave a message here: ☐ Yes ☐ No

Your Email Address: _____ May we leave a message here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Mobile Phone: _____ Home Phone: _____

CLIENT EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Annual Salary: ☐ $0 to $10,000 ☐ $10, 001 to $20, 000 ☐ $20, 001 to $40, 000 ☐ $40, 001 to $50, 000
☐ $50, 001 to $60, 000 ☐ $60, 001 to $80, 000 ☐ $80, 001 to $100, 000 ☐ More than $100,000

CLIENT EDUCATION INFORMATION

Last Year of School Completed: ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Are They Currently in School: ☐ Yes ☐ No If Yes, What Level: _____

School Attending: _____

Degree Pursuing: _____

CLIENT FAMILY OF ORIGIN

List Members of the Client's Immediate Nuclear Family or Origin *(Use back of necessary)*

1. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to Client: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Client's Relationship with Him/Her: _____
2. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to Client: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Client's Relationship with Him/Her: _____
3. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to Client: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Client's Relationship with Him/Her: _____
4. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to Client: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Client's Relationship with Him/Her: _____
5. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to Client: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Client's Relationship with Him/Her: _____

CLIENT MEDICAL INFORMATION

Primary Physician: _____ Phone: _____
Address: _____ City: _____ Zip Code: _____
Are they Currently Receiving Treatment: □ Yes □ No If Yes, Please Specify: _____
List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments They've Had *(Use back if necessary)*: _____
Have They Ever Had a Miscarraige: □ Yes □ No □ N/A
Abortion: □ Yes □ No □ N/A If Yes, □ Medical □ Non-Medical When: _____ Age: _____
Rate Their Physical Health: □ Very Good □ Good □ Average □ Declining □ Poor □ Very Poor
What Positive Things do They do to Impact Their Physical Health: _____

CLIENT MEDICATION INFORMATION

List All Current Medications They are Taking, Including Those They Seldom Use or Take Only as Needed

1. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
2. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
3. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
4. Medication: _____ Dosage: _____

Improves/Prevents/Controls: _____ Treating: _____

CLIENT SUBSTANCE USE

Do They Drink Alcohol or Use Drugs: □ Alcohol □ Drugs □ Both □ I Do Not Drink Alcohol or Use Drugs

Do They Smoke Tobacco: □ Yes □ No

If They use Alcohol or Drugs, What Kind do They use *(Check all that apply)*:

□ Beer □ Wine □ Liquor □ Marijuana/Pot/Hash/etc □ Cocaine/Crack/etc □ Sedatives/Valium/etc
□ Amphetamines/Speed/Meth/etc □ Opiods/Herion/Opium/etc □ Hallucinogens/Acid/Ecstasy/etc
□ Inhalant/HuffingWhipits/etc □ Phencyclidine/Mushrooms/etc □ Over the Counter/Prescription Meds

If They use Alcohol or Drugs, How Often do They use Them: □ Every Day □ Several Times per Week
□ Several Times per Month □ Once or Twice per Month □ Several Times per Year □ Once per Year

Have You Ever Felt Like They Should Cut Down on Their Alcohol or Other Drug Use: □ Yes □ No

If Yes, Explain: _____

Has a Friend or Relative Discussed Concerns About Their Use: □ Yes □ No

If Yes, Explain: _____

Have They Ever Felt Guilty About Your Drinking or Drug Use: □ Yes □ No

If Yes, Explain: _____

Have They Ever Had to Take a Drink or Use a Drug the Next Day to Steady Your Nerves: □ Yes □ No

If Yes, Explain: _____

Is There a History if Problems with Alcohol or Drug Use in Their Family: □ Yes □ No

If Yes, Explain: _____

Are They in Recovery from any Addictive Behavior: □ Yes □ No Explain: _____

Do They Engage in any of the Following Behaviors in such a way that it May be an Issue or Concern:

□ Gambling □ Spending □ Sexuality □ Eating □ The Internet □ Exercise □ Other: _____

CLIENT ABUSE HISTORY

Have They Ever Been Physically, Sexually, Emotionally, or Mentally Abused: □ Yes □ No

If Yes, Explain: _____

CLIENT LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT

Do They Have Past/Current Legal Involvement: □ Yes □ No

If Yes, Explain: _____

Have They Ever Been Involved with the Department of Children and Families (DCF) or a Similar Agency in Another State: □ Yes □ No

If Yes, Explain: _____

Have They Ever Been Involved in any Kind of Domestic Violence: □ Yes □ No

If Yes, Explain: _____

CLIENT PRESENTING CONCERN AND GOALS

Describe Their Reason for Coming to Counseling: _____

What Have They Done About it up to this Point: _____

What is Your Desired Result of Them Attending Counseling: _____

How Long do You Believe Counseling Should Last: _____

What Information Should be Known at the Outset of Counseling: _____

CURRENT STATUS

Check All of the Following Problems that Apply to the Client and/or Their Family:

Stress ----------□ Client □ Family
Panic----------□ Client □ Family
Anxiety----------□ Client □ Family
Nervousness--------□ Client □ Family
Shyness ----------□ Client □ Family

Physical Abuse ----□ Client □ Family
Sexual Abuse ------□ Client □ Family
Emotional Abuse--□ Client □ Family
Verbal Abuse ------□ Client □ Family

Trauma----------□ Client □ Family
Sexual Trauma ----□ Client □ Family
Head Trauma ------□ Client □ Family

Anger----------□ Client □ Family
Temper----------□ Client □ Family
Aggressiveness----□ Client □ Family
Loss of Control----□ Client □ Family
Impulsiveness------□ Client □ Family
Compulsivity ------□ Client □ Family

Apathy ----------□ Client □ Family
Unhappiness -------□ Client □ Family
Loneliness----------□ Client □ Family
Hopelessness-------□ Client □ Family
Defective Feelings□ Client □ Family
Unwanted Thoughts □ Client □ Family
Inferiority Feelings□ Client □ Family
Depression ---------□ Client □ Family
Self Injury----------□ Client □ Family
Suicidal Ideation --□ Client □ Family
Suicide Attempt---□ Client □ Family
Homicidal Ideation□ Client □ Family
Ambition----------□ Client □ Family

Concentration------□ Client □ Family
Racing Thoughts --□ Client □ Family
Making Decisions-□ Client □ Family
Guilt ----------□ Client □ Family

Grief----------□ Client □ Family
Recent Death-------□ Client □ Family
Terminal Illness---□ Client □ Family

Marriage ----------□ Client □ Family
Pregnancy ----------□ Client □ Family
Children----------□ Client □ Family
Being a Parent-----□ Client □ Family
Infidelity ---------- □ Client □ Family

Communication ---□ Client □ Family
Friends ----------□ Client □ Family

Legal Matters------□ Client □ Family
Finances ----------□ Client □ Family
Trouble with Job --□ Client □ Family
Career Choices ----□ Client □ Family

Sexual Problems --□ Client □ Family
Pornography -------□ Client □ Family

Alcohol Use--------□ Client □ Family
Drug Use ----------□ Client □ Family
Nicotine Use-------□ Client □ Family

Bad Dreams --------□ Client □ Family
Memory----------□ Client □ Family
Eating Problems---□ Client □ Family

CLIENT'S LEVEL OF DISTRESS

On a Scale from 1 to 10, Indicate Their Level of Distress *(1=Very Little Distress; 10=Extreme Distress)*

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Are They Currently Experiencing Any Suicidal Thoughts: □ Yes □ No

Have They Experienced Suicidal Thoughts in the Past: □ Yes □ No

Have They Ever Attempted Suicide: □ Yes □ No

If Yes, When and How: _____

Have Any of Their Friends or Family Members Ever Completed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PREVIOUS COUNSELING

Have They Ever had a Severe Emotional Upset? □ Yes □ No Explain: _____

List any Previous Counseling, Treatment, or Residential/In-Patient Care They Have Received:

1. Therapist: _____ Location: _____
   Dates Attended: _____ Reason: _____
2. Therapist: _____ Location: _____
   Dates Attended: _____ Reason: _____

What was the Outcome of any Prior Counseling: _____

CLIENT PERSONALITY INFORMATION

Mark All Words Which You Feel Best Describe Them:

□ Active □ Ambitious □ Self-Confident □ Persistent □ Nervous □ Hardworking □ Dedicated
□ Impatient □ Impulsive □ Moody □ Excitable □ Imaginative □ Calm □ Serious □ Easygoing
□ Shy □ Good-Natured □ Introvert □ Extrovert □ Depressed □ Likeable □ Leader □ Quiet
□ Submissive □ Self-Conscious □ Insecure □ Lonely □ Sensitive □ Passive □ Indifferent

Pick 5-7 Words Others Would Use to Describe Them: _____

CLIENT EMOTIONAL HEALTH

How Many Supportive People (Who They Can Depend On) do They Currently Have in Their Life:
□ None (0) □ Some (1-5) □ Average (6-10) □ Many (10+)

Have They Ever Attended a Support Group Addressing the Topic(s) for Which They are Seeking Counseling: □ Yes □ No Explain: _____

Have They Ever Been Hospitalized for Emotional/Psychological Concerns: □ Yes □ No

If Yes, Explain: _____

What Positive Things do They do to Impact Their Emotional Health: _____

CLIENT RELIGIOUS BACKGROUND/SPIRITUALITY

Do They Subscribe to a Religion/Form of Spirituality: □ Yes □ No Explain: _____

Do They Believe in a Higher Power: □ Yes □ No □ Uncertain

Is Their Religion/Spirituality a Source of Strength: □ Yes □ No □ Uncertain

Do They Regularly Attend a Place of Worship: □ Yes □ No If Yes, Where: _____

Do They Have a Spiritual Support System: □ Yes □ No If Yes, Who: _____

Would You Like Their Counselor to Address how Their Religion/Spirituality Might Assist Them in the Counseling Process: □ Yes □ No □ Uncertain

This concludes the psychosocial portion of the intake process. Thank you for taking the time to complete this inventory. The information that you have supplied will help to provide them with the best service possible.