Renewing the Mind Counseling Services
Client Intake Form

Name: ______________________________ **Today's Date:** ____________

DOB ________________ **Age** ______ Is client under 18 years of age? Yes ☐ No ☐

Name of Person filling out this form and reason: ______________________________

____

Address: ____________________ **City:** ____________ **ST:** ______ **Zip:** ________

Mailing Address (if different): ______________________________

Phone: (C) ________________ (H) ________________ (W) ________________

Email: ______________________________

May we leave a voice/text message? Yes ☐ No ☐ If yes, by ☐ cell ☐ home ☐ work ☐ email May we send you an appointment reminder? Yes ☐ No ☐ If yes, by ☐ text ☐ v-mail ☐ email

Employer: ____________________ **Occupation:** ____________________

Are you a student? Yes ☐ No ☐ If yes, name of school: ____________________

Emergency Contact: ____________ **Relationship:** __________ **Phone:** __________

Referred by: ____________________ May we send them a thank you? Yes ☐ No ☐

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling: ________________

____

____

When did these problems or issues develop? ______________________________

____

____

What are you hoping to achieve through counseling? ______________________________

____

____

Client Problem Assessment

Presenting Problem – Precipitating Stressors: "In recent months, I have been concerned about…"

Please check all that apply, past or present

☐ Marriage ☐ Spouse/Partner ☐ Parent/Child ☐ Family of Origin ☐ Extended Family
☐ Abuse (☐ physical ☐ sexual ☐ psychological ☐ neglect) ☐ Guilt ☐ Shame
☐ Cultural/Ethnic/Race ☐ Health ☐ Job ☐ Financial

Other: ____

Symptoms *Please check all that apply:*

☐ Decreased Concentration ☐ Decreased Motivation ☐ Decreased Energy
☐ Disturbance in Sleep Patterns ☐ Increased Stress ☐ Loss of Control
☐ Decreased Interest in Activities ☐ Numbness or Tingling ☐ Chest Pains / Discomfort
☐ Unexplained Physical Problems ☐ Body Tension ☐ Thoughts of Death/Suicide
Other ____

Major Life Events *Please check all that apply:*

☐ Death of a family member/friend ☐ Divorce ☐ Separation ☐ Imprisonment
☐ Personal injury/illness ☐ Marriage ☐ Job loss ☐ Pregnancy/complications
☐ Career change ☐ Legal problems ☐ Relocation ☐ Holidays ☐ Financial
Other: ____

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes ☐ No ☐
Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ☐ No ☐
Are you presently suicidal/homicidal? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: ____________________________________

____

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ☐ No ☐
Have you ever subjected another person to physical harm? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: ____________________________________

____

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses.

Strengths	**Weaknesses**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Living Arrangements

Current Address: ____ How Long: ____________

With whom do you live? ____

Current relationship with others where you live: ____________________________________

____

____

Relationship History

Sexual Orientation: ____

Are you married? Yes ☐ No ☐ If not married, are you in a relationship? Yes ☐ No ☐

Name and age of spouse/partner: ____

Date of marriage/cohabitation: ____

Previous marriage/relationship: Yes ☐ No ☐ If yes, name of spouse/partner: ______________

If yes, date of divorce/end of partnership: ___________________________________

Where children involved in the previous marriage/partnership: Yes ☐ No ☐

What is your perception of the status of your *current* relationship? *(include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.)* ______________________

____

____

Name, ages, and relational history of children from marriages/partnerships.

Name	**Age**	**Comments**	**Bio, Step, Adopted**

Developmental History

List the members of your family of origin/adoption and your compatibility with each one now.

Family Member	**Comments**

What was your birth order: # ____ of ____ children. Who primarily raised you? ______________

How would you describe your childhood? ☐ Uneventful ☐ Boring ☐ Traumatic ☐ Painful ☐ Unhappy ☐ Ignored ☐ Neglected ☐ Withdrawn ☐ Other ____________________

What was life like for you as a child? *(Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)* ____

____

____

____

Did you experience any traumatic events as a child or adult? *(Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)*

Date	**Age**	**Event**
____________	________	______________________________________
____________	________	______________________________________
____________	________	______________________________________
____________	________	______________________________________
____________	________	______________________________________
____________	________	______________________________________

Support System

Who do you depend on for support? *(Check all that apply)*

☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Employer ☐ Church ☐ Pastor
☐ Therapist ☐ Extended Family ☐ Neighbor(s) ☐ Close Friend(s) ☐ Co-Worker(s)
☐ Doctor(s) ☐ Support Group(s) ☐ Community Services ☐ Other: ________________

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes ☐ No ☐
If yes, explain who and why *(complete release of information consent form if needed)*: ____________________

____

____

Legal History *(Please explain all that apply, past and present)*

Charges as a minor: ____

Current Charges: ____

Arrests: ____

Convictions: ____

Parole/Probations: ____

Bankruptcies: ____

Divorce/Separation: ____

Foreclosures: ____

Civil Suits: ____

Financial Situation

Briefly describe your financial situation: ____

____

____

Work History

Describe your current job/career: ____

____

What do you like or dislike about your job and/or career?

Like	**Dislike**
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

____

____

Have you ever been fired from a job? Yes ☐ No ☐ If so, please explain: ____________________

____

Educational History

Describe what school was like for you: ____

____

Highest level of education: ________________ What kind of grades did you make? ____________

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

____

____

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background: ____

____

____

Do you have a religious/spiritual background? Yes ☐ No ☐ Preference ____________________

Do you attend religious/spiritual services? Yes ☐ No ☐ If so, where and how often? ____________

____

Medical History

How would you describe your current health? ______________________________

Are you currently on medications? Yes ☐ No ☐ If yes, please provide information.

Name of Medication	Dosage/Frequency	Prescribing Physician

Has it been more than a year since your last physical exam, including blood work? Yes ☐ No ☐

Have you had or were you involved with an abortion? Yes ☐ No ☐ Miscarriage? Yes ☐ No ☐

List any previous health issues including surgeries, procedures, and medical hospitalizations:

Problem	Date	Treatment

Counseling History *(Please list all previous psychotherapy experiences.)*

Are you or have you ever participated in counseling or psychotherapy treatment? Yes ☐ No ☐

If yes, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

Psychiatric History *(Please list all previous inpatient / outpatient experiences.)*

Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes ☐ No ☐

Have you ever been hospitalized for mental health related issues? Yes ☐ No ☐

Have you ever been hospitalized for mental health issues related to substance abuse? Yes ☐ No ☐

If you answered yes to any of the above, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep: ____

____

Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes ☐ No ☐ If yes, please explain.
Has anyone in your family had problems with alcohol or drugs that was not treated? Yes ☐ No ☐
If yes, please explain.

Family member	**Problem/Disorder**	**Treatment Results (if any)**
____________	______________	______________________
____________	______________	______________________
____________	______________	______________________
____________	______________	______________________
____________	______________	______________________

Substance Use / Abuse History

Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

Substance	**Amount**	**Frequency**	**Age of 1st use**	**Age regular use started**	**Age last used**
________	______	________	__________	__________________	_______
________	______	________	__________	__________________	_______
________	______	________	__________	__________________	_______
________	______	________	__________	__________________	_______
________	______	________	__________	__________________	_______

Have you experienced an increase in the use of alcohol and/or other substances? Yes ☐ No ☐
Do you see your usage as a problem? Yes ☐ No ☐ If yes, when did it become problematic?

____

____

Please describe any previous experience with substances or alcohol ___________________________

____

____

Please describe any family history of substance and/or alcohol use ___________________________

____

____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes ☐ No ☐ If so, please describe ______________________________

____

____

Nutrition

Have your eating habits changed recently? Yes ☐ No ☐ If so, please describe ___________________

____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes ☐ No ☐
Do you often eat out of depression, boredom, and/or anger? Yes ☐ No ☐ If yes, please describe

____

Do you use laxatives, water pills (diuretics), or diet medications? Yes ☐ No ☐ If so, how often and for what purpose do you use them? ____

____

Additional Information

Is there any other information that can be helpful for us to know about you? ____________________

____

____

____

____

____

____ ___________________________

Client Signature Date

For Office Use Only – Clinician Notes

____

____

____

____

____

____

____

____

____

____

____

Adverse Childhood Experiences Questionnaire
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **OFTEN** . . .
Swear at you, insult you, put you down, or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?
Yes ☐ No ☐ If yes enter 1 _______

2. Did a parent or other adult in the household **OFTEN** . . .
Push, grab, slap, pull your hair, or throw something at you?
OR
EVER hit you so hard that you had bruises, marks, or were injured?
Yes ☐ No ☐ If yes enter 1 _______

3. Did an adult or person at least 5 years older than you **EVER** . . .
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to or actually have oral, anal, or vaginal sex with you?
Yes ☐ No ☐ If yes enter 1 _______

4. Did you **OFTEN** feel that . . .
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?
Yes ☐ No ☐ If yes enter 1 _______

5. Did you **OFTEN** feel that . . .
You didn't have enough to eat, had to wear dirty clothes, and had no on to protect you?
OR
Your parents were too intoxicated to care for you or take you to a doctor if you needed it?
Yes ☐ No ☐ If yes enter 1 _______

6. Were your parents **EVER** separated or divorced?
Yes ☐ No ☐ If yes enter 1 _______

7. Was your mother, stepmother, grandmother, or other significant female caretaker . . .
OFTEN pushed, grabbed, slapped, had her hair pulled, or had something thrown at her?
OR
SOMETIMES or **OFTEN** kicked, bitten, hit with a fist or hit with something hard?
OR
EVER repeatedly struck over several minutes or threatened with a gun or a knife?
Yes ☐ No ☐ If yes enter 1 _______

8. Did you **EVER** live with anyone who was a problem drinker, an alcoholic, or used drugs?
Yes ☐ No ☐ If yes enter 1 _______

9. Has a household member **EVER** been depressed, mentally ill, or attempted suicide?
Yes ☐ No ☐ If yes enter 1 _______

10. Has a household member **EVER** been arrested, gone to jail, or been in prison?
Yes ☐ No ☐ If yes enter 1 _______

Now add up your "YES" answers: ______ This is your ACE score.