Jennifer Gess Consulting and Counseling Intake

Client Name:		Today's Date:
Legal Name:		Address:
Cell Number: Is it okay to leave a voicemail? □ No □ Yes		House Number: Is it okay to leave a voicemail? □ No □ Yes
Date of Birth:	Age:	Preferred Pronoun (eg: she, he, ze, they):
Self-identified Gender:		Primary Language:
Email address:		

What brings you in to counseling at this time?

Please answer the following question using 5-Excellent, 4-Good, 3-Average, 2-Poor, 1-Failing
How would you currently rate your mental health?

Symptoms
What are your current symptoms in order of what you find most bothersome:
1.
2.
3.
4.
5.

How are your symptoms affecting your ability to function at home? At work? In the community?

Mental Health History
Have you ever been in counseling before? □ No □ Yes
If yes, what did you find it helpful or effective, and unhelpful and uneffective?

Are you currently receiving any mental health services? □ No □ Yes
If yes, please list name of practitioner and type of services you are receiving:

Have you ever received a mental health diagnosis? □ No □ Yes

If yes, please list diagnosis/es and date (s) first diagnosed:

Have you ever been hospitalized for mental health concerns? □ No □ Yes

If yes, list date(s) and length of stay:

Have you ever or are you currently engaging in self-harm (such as cutting, etc)?

Currently: □ No □ Yes   Past: □ No □ Yes

If yes, what type of self-harm and how often?

Have you ever experienced (if yes, please explain):

Extreme depressed mood: □ No □ Yes

Extreme mood swings: □ No □ Yes

Rapid speech: □ No □ Yes

Extreme anxiety: □ No □ Yes

Panic attacks: □ No □ Yes

Phobias: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Eating disorder: □ No □ Yes

Repetitive behaviors (e.g., frequent checking, hand-washing) : □ No □ Yes

Homicidal thoughts: □ No □ Yes

Suicidal thoughts: □ No □ Yes

Suicide attempt: □ No □ Yes

RELEVANT PSYCHOSOCIAL HISTORY

Developmental History

Were there any complications with your birth? □ N □ Yes If so, please explain:

Did you reach developmental milestones within normal limits when you were a child (walking, talking, etc.)? □ N □ Yes

Were you hospitalized for any accidents, illnesses, or high fever when you were a child? □ N □ Yes If yes, explain:

Medical History (Include medications)

Please answer the following question using 5-Excellent, 4-Good, 3-Average, 2-Poor, 1-Failing

How would you currently rate your physical health?

Do you now have, or have you had in the past, any of the following? Check all that apply:

	Now	Past		Now	Past		Now	Past
Asthma			Allergies			Headaches		
Brain Injury			Epilepsy			Seizures		
Digestive Disorders			Cancer			Diabetes		
Breathing Problems			Immune System			Heart Disease		
High Blood Pressure			Vision Problems			Hearing Problems		
Arthritis			Urinary Disorders			Tuberculosis		
Thyroid Disorder			Multiple Sclerosis			Chronic Fatigue		
Fibromyalgia			Pregnancy (how many)			Miscarriage (how many)		
Abortion (how many)			STD's			Sleep Disorder		
Serious Accident			Surgery			Other		

Are you currently under the care of a medical doctor or other medical health professional: □ N □ Yes

Name of Primary Care Physician: ________________________ Physician Phone: _______________

Are you taking any prescription medications? □ N □ Yes If yes, please list:

List any over the counter medications, vitamins, or herbal supplements you are currently taking:

Do you currently exercise: □ N □ Yes If yes, please indicate what type and how many times per week:

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other __________________

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Educational History

What is the number of years of education you completed?

Or, what grade are you in? ____________ At which school? ______________

Degree(s) achieved from:

High School Diploma		G.E.D.	
Vocational/Trade		Associate Degree	
Bachelors Degree		Masters Degree	
Doctorate Degree		Other form of education	

Vocational History

Are you currently employed? □ No □ Yes If yes, please list title, name of employer, type of work, and length of time at employment:

Are you currently considering a change in job or career? □ No □ Yes If yes, what type of work are you interested in doing?

Have you ever served in the military? □ No □ Yes

If yes, please list branch, rank, and current status (active/discharged):

If deployed please list dates and family/relationship status pre and post deployment:

Trauma History

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s):

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Frequent/Multiple Moves			
Sexual Abuse				Homelessness			
Domestic Violence				Financial Problems			
Neglect				Lived over-seas			
Substance Abuse				Military member			
Serious Illness				Discrimination			
Accident or Injury				Other			

Family History (Include significant relationship history)

Were you adopted? □ No □ Yes If yes, your age at time of adoption:

With whom did you live until the age of 18? ____

Please list names, ages and relationship (positive, negative, neutral, etc) of those in your self-described family:

	Name	Age	Relationship		Name	Age	Relationship
1				2			
3				4			
5				6			
7				8			

Are your parents currently married/partnership? □ No □ Yes

Did your parents ever divorce? □ No □ Yes If yes, your age at time of divorce:

Were you ever in foster care or residential care? □ No □ Yes If yes, please list age and living situation:

Where did you live until the age of 18?

What is parent A's current age? ___________ If deceased, your age at time of his/her death: ___________

What is parent B's current age? ___________ If deceased, your age at time of his/her death: ___________

Are you currently in a relationship? □ No □ Yes

Name of person: ________________________

Length of time you have known each other:___________ Length of time together:

Do you currently live together? □ No □ Yes

Number of significant relationships: _________ Number of divorces: _________

Have you ever experienced the death of a family member or a close friend? □ No □ Yes

If yes, please list relationship and your age at time of their death:

Family History of Mental Illness

Has anyone in your family ever received a mental health diagnosis? □ No □ Yes
If yes, please list relationship(s) and illness(es):

History of Substance Use

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current	Amount	Frequency	Age	Past	Length
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
Other:						

Potential for Acute Intoxication, Withdrawal Problems or Relapse

Have you ever believed your substance use was a problem for you? □ No □ Yes

Has anyone ever told you they believed your substance use was a problem? □ No □ Yes

Have you ever had withdrawal symptoms when trying to stop using any substances? □ No □ Yes

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? □ No □ Yes

If yes, please describe:

Legal History

Have you ever been the victim of a crime? □ No □ Yes If yes, please list date and briefly describe:

Have you ever been convicted of a misdemeanor or felony? □ No □ Yes If yes, please explain:

Are you currently involved in divorce or child custody proceedings? □ No □ Yes If yes, please explain:

Developmental Disabilities

Have you ever been diagnosed with a Developmental Disability? □ No □ Yes
If yes, what was your diagnosis?

Social Issues and Stressors Affecting Treatment

Does your family/friends support you coming in for counseling? □ No □ Yes
If not, please explain:

Cultural Beliefs Affecting Treatment

What culture do you identify with? For some, this may include identity, race, religion or spirituality, etc. *or* Do your or your family have special things that you/they do?

Strengths and Interests

What are your strengths and interests?

Goals

What are the goals you hope to achieve in counseling:

1.

2.

3.

Is there anything you would like to add that I have not asked which you would like to include?

Client Signature: ______________________________ Date: ____________________

Parent/Guardian Signature: ___________________________ Date: ____________________

Thank you for your time! Please contact me with any questions.