***INTAKE DOCUMENT***

The Counseling Center of Ann Arbor

Name: SS#: Birth Date:

Gender: M F Phone #:

Cell/Home/Work (include Area Code)

Email:

Address:

Name of nearest relative we may contact in an emergency:

Street City State Zip Phone

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FAMILY AND SOCIAL HISTORY:***

Father's age: , or year of death: Mother's age: , or year of death:

Parents marital status: Married, Divorced, Separated, Widowed

With whom did you live while growing up?

Father's education: Occupation?

Mother's education: Occupation?

*Sibling Name Age Education Occupation*

Describe your relationship with your father:

Describe your relationship with your mother:

Describe your relationship with your siblings:

***YOUR MARITAL STATUS:***

Single, Married, Widowed, Divorced, Separated, Living together

First

Marriage: / / /

age/date no. of children date of divorce reason for divorce

Second

Marriage: / / /

age/date no. of children date of divorce reason for divorce

Your relationship with your present partner is: excellent, good, fair, poor

Conflicts over: money in-laws friends mental health problems

sex job legal problems communication alcohol/substance use

other (describe)

Names, ages and nature of relationship with your children:

*Name Age Description of Relationship*

With whom are you currently living? Relationship:

Describe your friendships: I have no friends, I have only acquaintances, I have close friends

I have both acquaintances and close friends How many close friends do you have?

*Interests/Activities/Organizations:*

reading hiking crafts night life shopping

dancing hunting music television writing

skiing drawing sports computers jogging

biking walking movies swimming workout

fishing cooking camping photography nature

environment Other (describe)

National or Ethnic background: Place of Birth:

Religious affiliation: Are you currently active? Yes No

***EDUCATION:***

What is the highest grade you have completed? Grade Level , GED , H.S. diploma

College , Degree: ,Vocational Training:

What is the highest grade your significant other has completed? Grade Level , GED ,

H.S. diploma ,College , Degree , Vocational Training

***EMPLOYMENT HISTORY:***

Present Employer:

Job Title: Starting Date: Hours/week:

Yearly income: Significant other’s yearly income:

How many employers in the last year: Past 2 Years?

Are you having any problems at work? Yes No

If yes, describe:

***LEGAL HISTORY:***

Current legal problems? Yes No Are you presently on parole or probation? Yes No

Past traffic violations other than parking? Yes No Past civil or criminal involvement? Yes No

***MEDICAL HISTORY:***

Name of family physician or the facility that you use for health care:

Name Address City/State Zip Phone

Date or approximate date, of last physical exam:

Rate the general state of your health: Good, Fair, Poor

Have you now, or in the past had any:

•Contagious diseases/infections? Yes No If yes, specify

•Disability/handicap? Yes No If yes, describe:

•Have your ever been hospitalized other than routine pregnancy? Yes No

If yes, specify

date reason

•Accidents/injuries? Yes No If yes, specify

Have you ever had a major illness? Yes No If yes, please give date and describe:

*Check all of the following difficulties that apply to you:*

thyroid problems menstrual problems low blood sugar asthma

diabetes mellitus high blood pressure migraine Headaches chest pains

stomach ulcers recent weight loss ulcerative colitis nutritional

trouble sleeping other headaches irritable bowel syndrome

seizures Other (specify)

Have you had previous psychotherapy or counseling? Yes No

If yes, when and where:

when where

Have you had suicidal thoughts or urges? Yes No

Have you attempted suicide? Yes No If yes, when:

Have you had homicidal thoughts or urges? Yes No

***SEXUAL HISTORY:***

Please describe your Sexual Preference (Straight, Gay, etc…):

Do you have sexual difficulties? Yes No

Do you engage in safe sex? Yes No

***ALCOHOL AND DRUG USE HISTORY:***

Do you take any drugs prescribed by a physician?

Name of drug Dose How often For What Purpose Date Prescribed

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please indicate on this chart, all of the drugs shown that you have used in the past or are using currently.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug name | Age of first  regular use | How much and  how often did  you use in the  past? | How much have  you used in the  last 48 hours? | How much do you use currently? | How often do you  use currently? |
| Alcohol |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Other |  |  |  |  |  |

Do you believe that you have a problem with drugs or alcohol? Yes No

Have there been incidents of overdose, withdrawal, or adverse reaction to drugs or alcohol? Yes No

If yes, describe:

Client Signature Date

Therapist Signature Date