Eclectic
THERAPY COLLECTIVE

Intake Form

Client's Full Legal Name: _____ Date: _____

Preferred Name: _____ Pronouns: _____

DOB: _____ Age: _____ Gender Identity: _____

Sexual Orientation: _____ Relationship Status: _____

Partner/Spouse Name: _____

Legal Custodian (if applicable): _____

Racial Orientation

- ☐ Native American
- ☐ Asian/Pacific
- ☐ African American
- ☐ Bi-Multi-Racial
- ☐ Hispanic
- ☐ Caucasian
- ☐ Other

Primary language: _____ Occupation: _____

Employer: _____

Reason(s) for seeking counseling services/presenting issue(s): (Check all that apply)

- ☐ Fears/Phobias/Worries
- ☐ Family Concerns
- ☐ Work Difficulties
- ☐ Sleeping Concerns
- ☐ Pregnancy/Adoption
- ☐ Depressed Mood
- ☐ Sexual Concerns
- ☐ Gender Identity
- ☐ Mood Swings
- ☐ Legal Concerns
- ☐ Drug/Alcohol Use
- ☐ Eating Concerns
- ☐ Court Appearance/Jail Term
- ☐ Divorce/Custody
- ☐ Loss/Change of Job
- ☐ Child Protection Investigation
- ☐ Financial Concerns
- ☐ Move to New Residence
- ☐ Concerns About Childhood
- ☐ Diagnostic Clarification
- ☐ Death/Illness of Close Friend/Family Member
- ☐ Mandated By: _____
- ☐ Other: _____
- ☐ Other: _____

When did the current issues first begin? _____

What changes do you want to happen as a result of counseling? _____

_____
_

What strengths, supports, or resources do you possess? _____

_____

What are some of your hobbies and/or interests? _____

_____

Are you currently engaged in any spiritual/religious activities?

☐ Yes ☐ No ☐ Unsure

Living Situation(s) During Childhood/Adolescence:

☐ Raised by both parents
☐ Parents split, raised by mother
☐ Parents split, raised by father
☐ Raised by another family member
☐ Raised in foster care/adoptive homes
☐ Other: _____

Current Living Situation of Client:

☐ Currently living in own residence
☐ With parent(s)
☐ Parents split, raised by father
☐ Living with a friend
☐ With foster family
☐ Homeless
☐ Temporary housing
☐ Hospital *
☐ Residential Care *
☐ Hospital *
☐ Nursing Home *
☐ Group Home *
☐ Jail
☐ Other: _____

* Please identify which facility you are at: _____

Primary Household Members:

Household Member	Relationship to Client	Age	Quality of Relationship

Additional Family Members or Other Support Persons:

Family/Support Person	Relationship to Client	Age	Quality of Relationship

Family History:

Is there any history of mental health issues on either side of your family?

☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

Is there any history of medical or physical health issues on either side of your family?

☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

Medical

Patient Care Communication: Eclectic Therapy Collective prides itself on providing the best service possible and understands the importance of communicating with all service providers to offer the best service to clients. With your permission, Eclectic Therapy Collective will coordinate your mental health services with your primary care physician.

Primary Care Physician: _____

Name of Clinic: _____

Psychiatrist/Medication-Prescribing Provider (if different than PCP above):

_____

Name of Clinic: _____

Do you have an Advanced Directive?

☐ Yes ☐ No

Health Concerns:

	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Head Injury					
Chronic Pain					

Trouble with Hearing					
Trouble with Vision					
Surgeries					
Serious or Chronic Illness					
Hospitalizations					
Allergies					
Infectious/Contagious Diseases					
Seizures (convulsions)					

Family medical concerns that impact you: _____

Other family concerns/stressors impacting you: (i.e. financial concerns, parents/relationship stress, etc):

_____

Medications:

Medication	Start	End	Dosage	Frequency	Note

Developmental Issues:

Are you aware of any complications during your mother's pregnancy with you?

☐ Yes ☐ No ☐ Unknown

Are you aware of any developmental concerns from birth to age 5?

☐ Yes ☐ No ☐ Unknown

Are you aware of any developmental concerns from birth to ages 6-18?

☐ Yes ☐ No ☐ Unknown

If you are aware of any developmental concerns you experienced, please describe:

_____
_____

Current Functioning:

Do you currently have any concerns about your: (check all that apply)

☐ Mood ☐ Sleep ☐ Executive functioning
☐ Energy ☐ Appetite ☐ Cognitive abilities

For any items checked above, please indicate when you were first concerned and describe your concerns:

_____

How many hours of uninterrupted sleep do you get per night? _____

How many hours per day do you spend on technology (not school/work related)? _____

Legal History

Do you have a history of legal charges?

☐ Yes ☐ No

If yes, describe: _____

Have you ever been court-ordered into chemical health or mental health treatment?

☐ Yes ☐ No

Chemical/Substance History

Do you have any concerns about your use of alcohol or drugs?

☐ Yes ☐ No

CAGE Assessment Tool (required):

Have you ever felt that you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning (eye opener) to steady your nerves, get rid of a hangover, or get the day started? ☐ Yes ☐ No

Substance Use:

	Current	Past	Never	Additional Info
Alcohol				
Street Drugs				
Prescription medication beyond prescribed usage				
Other				

Mental Health Treatment History

Previous and/or current mental health treatment? ☐Yes ☐No

Agency/Provider	Dates of Treatment

Please list any past diagnoses that you have received:

_____

Trauma History

Have you ever experienced or witnessed any of the following traumatic or upsetting events?

	During Childhood (age 0-17)	During Adulthood (age 18+)
None		
Physical Abuse		
Domestic Abuse		
Neglect		
Emotional Abuse		
Sexual Abuse/Molestation		
Community Violence		

Been involved with CPS		
Homelessness		

Safety/Risk Issues

- ☐ Do you have any of the following safety/risk concerns?
- ☐ Dangerous behavior to self
- ☐ Dangerous behaviors to others
- ☐ Destruction of property
- ☐ Risk of running away
- ☐ Need for supervision
- ☐ None reported