Walk in Balance Counseling

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672 W. Main St. ● West Haven, CT 06516

Counseling Intake Form
(All files are held in strict confidence)

About You:

First Name _____ MI _____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender: _____

Ethnic Identity

- ☐ Asian/Pacific Islander
- ☐ American Indian
- ☐ Black
- ☐ International Country: _____
- ☐ White
- ☐ Hispanic
- ☐ Jewish
- ☐ Other

What does being your ethnic identity mean to you?

Relationship Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Engaged
- ☐ Separated
- ☐ Widowed

Significant Other's Name:

How Long?

Is there anything you would like us to know about your partnership/ affectional identity?

Family Status

Any Children? If yes, please list names & ages

Address	City	State	Zip
Home Phone ☐ May We Leave A Message?	Email Address ☐ May We Send A Message?		
Cell Phone ☐ May We Leave A Message?			
Education Level (Highest Degree Achieved)	Current Academic Status ☐ FT ☐ PT	Graduation Date	
School	Major	Number of Credits This Semester	
Employer	Employment Status ☐ FT ☐ PT	Hours per week	

Religious Affiliation

- ☐ Catholic
- ☐ Jewish
- ☐ Protestant _____
- ☐ Spiritual
- ☐ Atheist or agnostic
- ☐ Other _____

Do you desire to have your religious beliefs and values incorporated into the counseling process?

☐ Yes ☐ No ☐ Not Sure

In case of emergency, contact:	Home Phone	Cell Phone

Please indicate who referred you to Walk in Balance Counseling?

Referral Type ☐ Self ☐ Friend ☐ Faculty ☐ Family ☐ Employer ☐ Healthcare Provider ☐ Court ☐ Other

Referral Name

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About What You Like:

What kind of hobbies do you like to do?	
What activities make you feel relaxed?	
What activities make you feel energized?	
On a scale from 1 to 5, with 1 meaning that you do not enjoy at all and 5 meaning you very much enjoy, rate each of the following activities:	
Art – Painting, Drawing, Photography, etc.	_____ (out of 5)
Writing – Poetry, Journaling	_____ (out of 5)
Gardening – herbs, flowers, vegetables, houseplants	_____ (out of 5)
Pets – spending time with animals	_____ (out of 5)
Music – playing or listening to music	_____ (out of 5)
Yoga – practicing yoga and meditation	_____ (out of 5)
Physical Activity – fitness & sports	_____ (out of 5)
Counselor Comments:	

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About What Your Life is Like:

Answer the following:				
☐	Yes	☐	No	I have graduated from high school.
☐	Yes	☐	No	I receive (or have received) mostly A's in school and/or college.
☐	Yes	☐	No	I have a special talent, such as drawing, playing music, sports, etc.
☐	Yes	☐	No	I participate in other fun activities outside of work and school.
☐	Yes	☐	No	My family is functioning well and supportive of me.
☐	Yes	☐	No	I am in good physical health.
☐	Yes	☐	No	I feel that I have good social skills, i.e. I do not worry about being around other people.
☐	Yes	☐	No	I feel part of a community.
☐	Yes	☐	No	I have several good friends that are supportive of me.
☐	Yes	☐	No	I feel successful at my work.
☐	Yes	☐	No	I know what I want to do with my life.
☐	Yes	☐	No	I feel that my life has meaning and purpose.

List the first names of people you consider to be your best friends (people – including family -- that support you and you can rely on no matter what):

Counselor Comments:

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About What Brings You Here Today:

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Negative Towards Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

If you are currently taking any medication(s), please list the type, dosage, and the purpose for each below:

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*Counselor Name:*_____ *Date:*_____

Please describe the concerns that you would like to discuss with a counselor:

How long has this problem persisted?	Under what condition do your problems get worse? better?

Please use the following scale to answer the next three questions:

	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

☐ Have you previously been involved in counseling?

☐ Is there a history of mental health problems in your family?

☐ Have you ever been physically abused?

☐ Have you ever been emotionally abused?

☐ Have you ever been sexually abused or assaulted?

☐ Have you ever attempted suicide?

☐ Have you ever been hospitalized for mental health reasons?

☐ Is there a history of alcohol or drug problems in your family?

Counselor Comments:

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Parents:

Family History	Mother's Age _____ If deceased, how old were you when she died? _____ Father's Age _____ If deceased, how old were you when he died? _____ If your parents are separated, how old were you then? _____ Number of brother(s) _____ What are their ages? _____ _____ _____ _____ Number of sister(s) _____ What are their ages? _____ _____ _____ _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:	Briefly describe your father's personality:

Briefly describe your stepparent(s) personality:

Briefly describe your past and current relationships with your:

Mother	Father
Stepmother	Stepfather

Counselor Comments:

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Developmental Life Interview:

What do you remember most about the following times? Anything remarkable good or bad?	
Pre-School (3-5 years):	School-Age (5-12 years):
Adolescence (13 to 22 years):	
Early Adulthood (22 to 30 years):	
Middle Adulthood (30 to 60 years)	
Late Adulthood (60 years +)	
Counselor Comments:	