MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

CONFIDENTIAL CLIENT INTAKE SUMMARY

Last Name: _____ First Name: _____ Date:_____

Address: _____ City: _____ State_____ Zip: _____

I cannot guarantee confidentiality when you and I are communicating via cell phone, cordless phone, fax, email, mail or computer. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools. It is our normal practice to communicate with you at your home address and daytime phone number, provided when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes, we may leaves messages on your voicemail. You have the right to request that our office communicate in a different way.

Home Phone: _____-_____-_____ May we leave a message at this number? ☐ Yes ☐ No

Cell Phone: _____-_____-_____ May we leave a message at this number? ☐ Yes ☐ No

Email Address: _____ May we leave a message at this address? ☐ Yes ☐ No

Birthdate: _____-_____-_____ SSN: _____-_____-_____

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Partnered
☐ Widowed

Student Status:
☐ Not a student
☐ Full-time
☐ Part-time
☐ School Name: _____

Employment Status:
☐ Full-time
☐ Part-time
☐ Self-employed
☐ Not-employed
☐ Retired
☐ Active Military Duty
☐ Unknown
☐ Other: _____
☐ Employed By: _____
☐ Occupation: _____

Referred By:
☐ Community Event: _____
☐ Current/Former MWR client
☐ EAP Provider: _____
☐ Friend/Family/Colleague
☐ Google/Online search
☐ Insurance Provider
☐ Medical or health provider: _____
☐ Psychology Today
☐ School
☐ Social media
☐ Other: _____

Send E-statements to review your account online? ☐ Yes ☐ No
Email Appointment Reminders? ☐ Yes ☐ No
Text Appointment Reminders? ☐ Yes ☐ No
Appointment reminder Number _____-_____-_____ Cellphone Carrier: _____
Emergency Contact: _____ Relationship: _____ Phone: _____-_____-_____

Goals of Counseling
(If you need more space, please use the back of this form)

Brief description of why you're seeking counseling at this time: _____

_____

_____

In what ways has this interfered with your daily functioning? _____

_____

What do you see are your strengths? _____

What would you like to change and achieve through counseling? _____

_____

What things have you done to try and address this issue? _____

_____

Psychosocial and Medical History Assessment

Social/Family Background

Please briefly describe your current living arrangements:

_____

Do you have children? Please list any pertinent details: _____

Who are your sources of support? _____

Please briefly describe your relationship status:

Educational/Occupational Background

What is your education history and highest level completed?_____

Any learning problems or learning disabilities? _____

What is your occupation and how long have you been employed in that position? _____

_____

Are you currently experiencing any impairment in educational or occupational functioning? _____

_____

Cultural Background

Raised by/lived with: _____

Place(s) raised: _____

Religious/Spiritual Background: _____

Ethnicity: _____

Cultural Background (traditions, values, practices): _____

Medical and Psychiatric History

Current Medications: _____

Previous Medications: _____

Allergies: _____

Relevant medical conditions: _____

Major illnesses, injuries, diagnoses, surgeries: _____

_____

Describe current health problems/concerns: _____

How do you rate your overall health? ☐ Excellent ☐Good ☐Fair ☐Poor

Do you exercise regularly? ☐ Yes ☐ No If yes, what types of exercise? _____

Current Physician: _____ Current Psychiatrist: _____

Previous Outpatient Counseling? ☐ Yes ☐ No
Previous counseling or psychiatrist providers (treatment dates, response to treatment and medication): _____

_____

Previous mental health or medical hospitalizations? ☐ Yes ☐ No
If yes, please briefly describe: _____

Any other services you are involved with for your mental health/medical care? _____

Would you like to sign a release of information to your primary care physician or psychiatrist for coordination of care? ☐ Yes ☐ No

Maternal Mental Health/Medical History

Number of pregnancies _____ Abortion _____ Miscarriage _____ Live birth _____

Complications during pregnancy/delivery/postpartum: _____

_____

How would you describe your birth(s)? Did you experience anything you consider traumatic? _____

_____

Are you currently breastfeeding? ☐ Yes ☐No

Previous history of postpartum depression/anxiety? ☐ Yes ☐ No

Any prenatal, birth, infancy concerns for self?: Please describe**.** _____

_____

Substance Abuse Assessment

Past alcohol consumption patterns (how much, how often, how long): _____

_____

Current Alcohol consumption patterns (how much, how often, how long: _____

_____

Past Drug use patterns (how much, how, often, how long): _____

_____

Current Drug use patterns (how much, how often, how long): _____

_____

Past Nicotine use patterns (how much, how often, how long): _____

Current Nicotine use patterns (how much, how often, how long): _____

Caffeine use (how much, how often, for how long): _____

Family Mental Health and Substance Abuse History
(Please indicate who and when)

- ☐ Alcohol Abuse_____
- ☐ Drug Abuse_____
- ☐ Depression_____
- ☐ Anxiety/Panic_____
- ☐ Other mental illness_____
- ☐ Disability_____
- ☐ Adoption_____
- ☐ Foster Care_____
- ☐ Suicide_____
- ☐ Other deaths_____
- ☐ Learning Problems_____
- ☐ Health Problems_____
- ☐ Parental Violence_____
- ☐ Divorce/Separation_____
- ☐ Physical Abuse_____
- ☐ Sexual Abuse_____
- ☐ Rape_____
- ☐ Imprisonment_____
- ☐ Active Combat_____
- ☐ Natural Disaster_____
- ☐ Work problems_____
- ☐ Relationship problems_____
- ☐ Legal Problems_____
- ☐ Financial Problems_____

Please check any of the following that apply:

- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear
- ☐ Restlessness
- ☐ Anger
- ☐ Frustration
- ☐ Confusion
- ☐ Shyness
- ☐ Feeling inadequate
- ☐ Disorganization
- ☐ Difficulties making decisions
- ☐ Stress
- ☐ Loneliness
- ☐ Guilt
- ☐ Shame
- ☐ General unhappiness
- ☐ Restrict Food
- ☐ Binge/Purge food
- ☐ Depression
- ☐ Grief
- ☐ Crying spells
- ☐ Boredom
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Thoughts of hurting others
- ☐ Unwanted thoughts/rituals
- ☐ Problems at work
- ☐ Relationship problems
- ☐ Concern about sexuality
- ☐ Financial concerns
- ☐ Physical problems/pain
- ☐ Disturbing fears
- ☐ Communication difficulties
- ☐ Depending too much on others
- ☐ Inability to stop doing certain things
- ☐ Memory lapses, blank periods
- ☐ Unable to concentrate
- ☐ Headaches
- ☐ Aches/pains
- ☐ Abdominal problems
- ☐ Fatigue
- ☐ Low energy
- ☐ Poor motivation
- ☐ Nightmares
- ☐ Unwanted memories or images
- ☐ Cutting, burning or other self-harm
- ☐ Sudden impulses
- ☐ Difficulties coping with daily demands
- ☐ Difficulties trusting others
- ☐ Secrets I'm afraid to tell
- ☐ Hearing voices/seeing things others don't see/hear
- ☐ Alcohol or drug abuse problem
- ☐ Changes in sleep patterns
- ☐ Changes in weight (+/-) _____lbs
- ☐ Legal Issues _____

Risk Assessment

Have you had any previous thoughts or urges to harm yourself or someone else? ☐ Yes ☐ No
If yes, please describe: _____

Have you had any previous suicide attempts? ☐ Yes ☐ No
If yes, please describe (when, method, dates of hospitalizations): _____

Have you had any previous attempts to physically harm someone else or others? ☐ Yes ☐ No
If yes, please describe this incident: _____

Have you been the victim or perpetrator of any domestically abusive or violent situations? ☐ Yes ☐ No
If yes, please describe: _____

Have you been the victim of any other crimes, natural disasters, or other trauma? ☐ Yes ☐ No
If yes, please describe: _____

Trauma/Abuse Assessment

☐ Physical Abuse Who: _____
☐ Emotional Abuse Who: _____
☐ Sexual Abuse Who: _____
☐ Rape/Assault Who: _____
☐ Neglect: Who: _____
☐ Accidents/childhood losses Who: _____