RESILIENCE1220
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Client Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Name of client: _____
(Last) (First) (Middle initial)

Age: _____ **Birthdate:** _____**Gender Identity:** _____**Pronouns**: _____

Name of individual inquiring about counseling (if other than client) and **Relationship to Client:**

_____
(Last) (First) (Middle initial)

Home Address: _____
(Street Number)

_____
(City) (State) (Zip Code)

Client Phone: _____ **Okay to leave a message**? ____yes____no

Parent/Legal Guardian's Phone (if applicable): _____
Okay to leave a message? ____ yes ____ no

Email: _____
Okay to email a message? ____ yes ____ no
please note that email is not always considered confidential

Emergency Contact Information: (Name, Relationship, Phone #):

_____

How did you find out about Resilience 1220? _____

What is your reason for reaching out for counseling: _____

_____

Are you interested in learning about our groups and other programming for teens/parents?
___ yes ___ no

School and Social Life

Do you currently attend school? ____ yes _____ no

Name of School: _____ **Grade:** _____

Do you have any specific learning differences or challenges? _____ yes _____ no

If yes, please describe: _____

Do you receive any accommodations or services at school: ____ yes ____ no If so, please list:

_____

Would you like us to speak with your School Counselor, Teacher or other School Staff member:
_____ yes _____no

Do you enjoy school? ____ yes ____ no

If no, what would you change? _____

How happy are you with your social life?
____ Very happy ____ Somewhat happy ____ Kind of unhappy ____ Very unhappy

What would you change?_____

_____

Are you in a romantic relationship? _____ yes _____ no

Are you being bullied or picked on (in person or online)? _____ yes _____ no

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?

_____

_____

What do you view to be your strengths as a person?

_____

_____

What are your extracurricular interests/passions/hobbies?

_____

_____

Do you participate in social media and/or online gaming? _____ yes _____ no

If yes, please describe which ones:_____

_____

How many hours per day (on average) do you spend on social media? _____
How many hours per day (on average) do you spend gaming?_____
Have you had any troubling or negative experiences with social media and/or gaming?
_____ yes_____ no
If yes, please describe:

_____

_____

For me, social media sites are a source of :
(On a scale of 1-10, with 1 being extremely comforting and 10 being extremely stressful, please circle)

1 2 3 4 5 6 7 8 9 10
Comfort Stress

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Family Information

Who lives in your home? If you have siblings, how old are they?

_____

_____

Who do you turn to for support in your family? _____

_____

Are there any conflicts at home that are hard to handle? _____ yes _____ no
If so, please describe:

_____

Have you experienced any significant life events that have been challenging for you (ex. Losses, divorce, violence, moves, etc.)?

_____

Please list any mental health conditions that exist within your family, as well as the family member with the condition:

_____

_____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:

_____

_____

Is there any history of suicide in your family? If so, please list:

_____

Do you have access to guns in your home? _____ yes _____ no

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Health and Medical

Have you previously received any type of mental health services, such as counseling or psychiatric services? ___ yes ___ no

If yes, what?: _____

Have you previously been diagnosed with a mental health condition? ___ yes ___ no
If yes, what was your diagnosis?

_____

Are you currently working with other mental health providers (psychiatrist; other counselors)? ___ yes ___ no

If yes, please provide their name(s) and type of work you do with them (medication, etc.):

_____

Would you like us to speak with your other providers for additional information/support?
_____ yes _____ no

Please list current prescription psychiatric medication that you are taking:

_____

Have you ever been hospitalized for your mental health? _____ yes _____no
If yes, when and where were you hospitalized?

_____

How would you describe your current physical health? (please circle one):

Poor Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions: _____

_____

Please check from the following list any items that you have experienced recently:

___ Loss of interest in previously enjoyed activities
___ Overwhelming sadness and/or crying often
___ Feeling hopeless
___ Feelings of loneliness and isolation
___ Overwhelming anxiety, panic, or worry
___ Frequent physical complaints (headaches, stomachaches, etc)
___ Significant change in weight
___ Worries about your body and eating patterns
___ Trouble falling asleep or staying asleep at night
___ Nightmares or recurring, upsetting memories
___ Problems due to social media use or gaming
___ Racing or disorganized thought patterns
___ Thoughts of suicide or self-harm
___ Thoughts of harming others or animals
___ Self-injury or self-destructive behavior
___ Irritability or anger
___ Mood swings
___ Outbursts, tantrums
___ Aggression towards others or animals (past/recent)
___ Use of alcohol or recreational drugs
___ Difficulty paying attention/ distractibility
___ Repetitive thoughts or behaviors
___ Significant changes in grades/school performance
___ Resistance to attending school
___ Relationship struggles with friends
___ Romantic relationship problems
___ Problems related to my screen use
___ Problems with the law (police or court involvement)
___ Gender Identity or sexuality challenges
___ Spiritual or cultural concerns