Carolina BEHAVIORAL COUNSELING

Demographic Information

Name: _____ DoB: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Trans* ☐ Non-Binary/GNC ☐ Preferred Pronouns: _____

Address: _____

City, State, Zip: _____

Phone Number: (_____)_____ Email: _____

Okay to leave voice message? ☐ Yes ☐ No Any special instructions? _____

Okay to text/email appointment reminders? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____

Phone Number: (_____)_____ Okay to leave voice message? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Partner: _____

	Extremely Dissatisfied				Extremely Satisfied
Relationship Satisfaction:	1	2	3	4	5

How did you hear about Carolina Behavioral Counseling? _____

Current Situation

Briefly describe why you are seeking counseling at this time: _____

_____

_____

How long has this been a problem for you? _____

Have there been times when this issue got better or disappeared? ☐ Yes ☐ No

If yes, when? _____

Have there been times when this issue was particularly difficult to cope with? ☐ Yes ☐ No

If yes, when? _____

What goals would you like to achieve while in counseling? _____

_____

_____

Who do you identify as your support system? Please list names and relationships: _____

_____

_____

What are your current living arrangements?
☐ own home/apartment ☐ family's home/apartment ☐ shared home/apartment ☐ other: _____

Who else lives in the home with you? Please list names and relationships: _____

_____

Health History

Have you ever received counseling services? ☐ Yes ☐ No
If yes, when? _____ Successful? ☐ Yes ☐ No

Have you ever been hospitalized for a mental health condition? ☐ Yes ☐ No
If yes, when? _____ Duration of Stay: _____

Have you ever been diagnosed (to your knowledge) with a mental health condition? ☐ Yes ☐ No
If yes, what diagnosis? _____

Have you ever received detoxification treatment? ☐ Yes ☐ No
If yes, when? _____ Substance(s): _____

Please list any prescription medications:

Name of Medication	Dosage/Frequency	Reason for Medication	Prescribing Doctor	Date Prescribed

Are you medication compliant? ☐ Yes ☐ No

Please list any major surgeries and dates: _____

How would you rate your overall mental health on a scale of 1-10 (1 is poor, 10 is excellent): _____

How would you rate your overall physical health on a scale of 1-10 (1 is poor, 10 is excellent): _____

Please list any medical conditions or any disabilities: _____

Education and Employment

What is the highest education you have completed? ☐ some high school ☐ GED ☐ High School diploma ☐ some college ☐ Associates degree ☐ Bachelors degree ☐ Masters degree ☐ Doctoral degree

Where did you obtain this degree? (Name of school): _____

Major Field of Study: _____

Any problems associated with your education? _____

What type of student would you describe yourself as? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current employment (Check all that apply):
☐ Unemployed ☐ Part-Time Student ☐ Full-Time Student ☐ Part-Time Job ☐ Full-Time Job

If employed, please list company and position: _____

	Extremely Dissatisfied				Extremely Satisfied
School or Job Satisfaction:	1	2	3	4	5

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Family Background

Do you have any children? Please list names and ages: _____

_____

Who do you identify as your immediate family members? Please list names and relationships:

_____

_____

Please indicate who was involved in your life during childhood:

	Present entire childhood	Present part of childhood	Not present at all	Deceased
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐
Stepparent(s)	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

Name and relationship: _____

How would you describe your family relationships during childhood? ***Check all that apply.***
☐ Good ☐ Fair ☐ Poor ☐ Close ☐ Stressful ☐ Distant ☐ Chaotic ☐ Abusive ☐ Other: _____

How would you describe your family relationships currently? ***Check all that apply.***
☐ Good ☐ Fair ☐ Poor ☐ Close ☐ Stressful ☐ Distant ☐ Chaotic ☐ Abusive ☐ Other: _____

Describe your level of desire for family support and involvement in your treatment process: _____

_____

Have you ever served in the military? ☐ No service ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines
☐ National Guard ☐ Navy ☐ Reserves | ☐ Family Member (name and branch): _____

What is your religious identification? _____

How important is your faith to you? Not at all 1 2 3 4 5 Extremely important

***Psychiatric Family History**: Check all that apply*

	Mother	Father	Siblings	Aunt/Uncle	Maternal Grandparent	Paternal Grandparent	Other Relative
Alcohol/Substance Abuse							
Suicide attempt or died by suicide							
Depression							
Anxiety							
Schizophrenia							
Bipolar Disorder							
Alzheimer's							
ADHD							
Learning Disorder							
Eating Disorder							
PTSD							
Personality Disorder (Diagnosed)							
Other Mental Illness							

***Trauma History**:*

			Perpetrator	Duration	Age of First Occurrence
Physical Abuse	☐ Yes	☐ No	_____		
Sexual Abuse	☐ Yes	☐ No	_____		
Emotional Abuse	☐ Yes	☐ No	_____		
Other Abuse	☐ Yes	☐ No	_____		

If you indicated 'yes' to any abuse above, have you ever received counseling for this trauma? ☐ Yes ☐ No

Substance History

In the past **6 months**, have you used any alcohol or other chemical drug? ☐ Yes ☐ No

If yes, please indicate name of substance and amount used: _____

In your **lifetime**, have you ever used any alcohol or other chemical drug? ☐ Yes ☐ No

If ***no***, please ***skip*** the following section. If ***yes***, please ***complete*** the following section.

Substance Use History: *Complete this section if you have* ***ever*** *used* ***any*** *substance*

Drug	Age of First Use	Age of Heaviest Use	Recent Pattern of Use (Frequency/Amount)	Date of Last Use
Alcohol				
Cannabis (Marijuana)				
Cocaine				
Methamphetamine				
Opioids (heroin, narcotics, methadone)				
Prescription medications (not taken as prescribed)				
Stimulants (crystal, speed, amphetamines)				
Tobacco (smoke, chew)				
Other (please specify): _____				

Drug of choice: (1) _____ (2) _____ (3) _____

How would you rate your desire for sobriety from any/all substances?

No desire, no intent 1 2 3 4 5 6 7 8 9 10 Full desire and intent

Risk Assessment

Are you currently having thoughts of harming yourself? ☐ Yes ☐ No
Are you currently having thoughts of harming someone else? ☐ Yes ☐ No
Are you currently having thoughts of killing yourself? ☐ Yes ☐ No
Are you currently having thoughts of killing someone else? ☐ Yes ☐ No
Do you currently have access to any means of harm (e.g., weapons, prescription medications)? ☐ Yes ☐ No

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Client Name (Please Print): _____

Client Signature: _____ Date of Completion: _____

By signing above I acknowledge that I have read and understand this intake form, and that I have provided honest answers to the best of my knowledge. It is my responsibility to seek further clarification from Carolina Behavioral Counseling if necessary.