Premier Counseling+

Brenda Wachter, LMSW, ACSW, CMHIMP

Intake - Social History

Name:

What are you being seen for?

When did it start and how long has this been going on?

Stressors

Which of the following stressors do you experience (Circle all that apply)?
Family, Friends, Relationships, Educational, Economic, Occupational, Housing, Legal, Health

Physical Symptoms

Please list any physical symptoms you are experiencing, including high blood pressure, chronic pain, trouble sleeping, headaches, dizziness, etc.

Substance Abuse History

Do you have a history of any recreational drug use?
Please list any you have used, how old you were, and how much you used.

Have you ever received substance abuse treatment?
If so, please explain.

Inpatient History

Do you have a history of inpatient psychiatric treatment?
If yes, please list facility, primary reason for treatment, how old you were, and if your stay was voluntary.

Outpatient History

Do you have a history of outpatient counseling?
If yes, please list the provider you saw, your primary reason for seeking treatment, your age, and whether or not it was helpful.

Suicide/Self Harm History

Have you ever tried to harm or kill yourself?
If yes, please explain how old you were and what method was used.

Violence History

Do you have a history of violent behavior?
If yes, please explain.

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Medical History

Who is your primary Physician? When did you last see him/her?

Are you taking any medications or supplements currently?
Please list name and dose.

Please list any medical issues you have had or are currently experiencing:

Please list any surgeries you have had.

Psychiatric Medication History

Have you ever taken any medication for psychiatric treatment (anxiety, depression, ADHD, etc.)? If yes, please list name, dose, start and end date, whether or not it was helpful, any side effects, and your reason for stopping it.

Family History

Do you have any family members with a history of mental health issues (anxiety, depression, ADHD, Bipolar Disorder, etc.)? If yes, please list family member and problem.

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following (circle all that apply)?
Exposure to drugs or alcohol during pregnancy, A difficult pregnancy, Problems with delivery, Other

Did you have any complications after your birth? (for example, premature birth, jaundice, breathing difficulties)

Did you have any delays or difficulties in reaching developmental milestones such as walking or talking?

Which options below best describe your childhood home atmosphere (circle all that apply)?
Normal, Supportive, Parental fighting, Parental violence, Financial difficulties, Frequent moving

Which of the following challenges were experienced during your childhood (circle all that apply)?
Bed Wetting, Stealing, Fire setting, Animal cruelty, Separation anxiety, School anxiety, Victim of bullying, Depression, Anxiety, Death of a parent/caregiver, Parental divorce, Other

Please list 3 words that describe your K-12 school experience:

What is the highest level of education you have completed?

General Social History

Which options below best describe your social situation (circle all that apply)?
Supportive social network, Few friends, No friends, Distant from family of origin, Family conflict, Other

Are you currently married?

How many times have you been married?

Who do you currently live with (circle all that apply)?
Children, Spouse, Roommates, Siblings, Parents, Live alone, Other

Do you currently participate in spiritual activities?

Are you currently employed?
Full time?
Part time?

Menstruation and Pregnancy History

Which of these best describe your premenstrual symptoms (circle all that apply)?
Cramps, Appetite change, Bloating, Sleep disturbance, Feel down, Feel anxious, Feel irritable, Other

Have you ever been pregnant? If yes, how many times?

Have you ever given birth? If yes, how many times?

Have you ever had a miscarriage? If yes, how many times?

Have you ever had an abortion? If yes, how many times?

Sources of Risk

Do you have a history of being sexually, physically, or verbally abused?

Do you have any thoughts about cutting, harming, or killing yourself?

Do you have any thoughts about hurting someone else?

Lifestyle
Do you exercise regularly?

Describe:
Average number of hours you sleep per night:

Trouble falling asleep?

Trouble staying asleep?

Awake before rested?

Is your diet well balanced?

Average caffeine intake per day?

Do you use nicotine?

Do you use marijuana?

Describe alcohol intake (what type and servings per day/week/month):

What are your top 3-5 goals/desired outcomes for your treatment?