PHOENIX
COUNSELING & CONSULATION
beauty from ashes

INTAKE INVENTORY

Please complete this inventory as carefully as possible. Answer each item if it applies to you All information you provide will be treated confidentially. Additionally, the information will become part of your record.

DEMOGRAPHIC INFORMATION

Name:_____ Date:_____

Home Address:_____

_____

Phone (Home)_____ (Work)_____ (Cell) _____

Sex:_____ Date of Birth:_____ Age:_____

E-Mail Address: _____

Occupation:_____ Hours Per Week:_____

Employed By:_____

Referred Here By:_____ Phone:_____

Emergency Contact:_____ Phone: _____

Contact's Address:_____

MARRIAGE INFORMATION

Intimate Relationship:

- ☐ Never been in a serious relationship
- ☐ Currently in a casual relationship
- ☐ Cohabitating
- ☐ Not currently in a relationship
- ☐ Currently in a serious relationship
- ☐ Married

If currently or ever married….

What Year Married?:_____ How Long Did You Date?:_____

How Did You Meet?:_____

Did Your Parents Approve Of Marriage?_____Spouse's Parents?:_____

Have You Ever Been Married Before?:_____

Number of Divorces?_____ How Long Divoced?_____

Relationship Statisfaction:

- ☐ Very satisfied with relationship
- ☐ Satisfied with relationship
- ☐ Somewhat satisfied with relationship
- ☐ Dissatisfied with relationship
- ☐ Very dissatisfied with relationship

Please List Your Relationships Below. List Your Children Beginning With The Oldest. (Place a check by the child's name if from a previous marriage)

Relationship	**Name**	**Age**	**Grade/Occupation**
SPOUSE	_____	____	_____
EX-SPOUSE	_____	____	_____
CHILDREN	_____	____	_____
(or siblings if	_____	____	_____
under 18 yrs.)	_____	____	_____
	_____	____	_____
MOTHER	_____	____	_____
FATHER	_____	____	_____

FAMILY INFORMATION

What kind of childhood home environment did you have?

- ☐ Outstanding Home Environment
- ☐ Normal Home Environment
- ☐ Chaotic Home Environment
- ☐ Unstable Home Environment
- ☐ Witnessed Physical, Verbal, and/or Sexual Abuse toward Others
- ☐ Experienced Physical, Verbal, and/or Sexual Abuse from Others
- ☐ Frequent Moves

Did anyone else have a key role in your upbringing? (If so, who and why):_____

_____

How many children are/were in your family ? (Brother & Sisters)_____

What child are you by number?

☐ Oldest ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ Youngest ☐ Other

PRESENT DURING CHILDOOD:

Caregiver	Quality of Relationship	Present Entire Childhood	Present Part of Childhood	Not Present at All	# of Divorces	# of Marriages	Age & Year of Death (if applicable)
Mother							
Father							
Stepmother							
Stepfather							
Brother(s)							
Sister(s)							
Grandparent							

EDUCATION

Highest Level/Grade of Education Completed:

☐ Not Complete HS ☐ High School ☐ Some College ☐ AA Degree

☐ College (Major:_____) ☐ Graduate (Major:_____)

How well did you do in elementary school? _____

How well did you do in HS? _____

How well did you do in College? _____

How well did you do in Graduate School? _____

MILITARY

Have you served in the military? ☐ Yes ☐ No, If yes which branch: _____

How many years did you serve? _____

Did you see active combat? ☐ Yes ☐ No

Approxminately how much time did you spend away from your wife and children?

_____

Did you receive an honorable discharge? ☐ Yes ☐ No

SOCIO-ECONOMIC HISTORY

Housing:

- ☐ Housing Adequate
- ☐ Homeless
- ☐ Housing Overcrowded
- ☐ Housing Inadequate
- ☐ Housing Dangerous
- ☐ Dependent on Others for Houseing

Social Support System:

- ☐ Supportive Friends/Network
- ☐ Substance-Use Friends
- ☐ Distant From Family of Orgin
- ☐ Few Friends
- ☐ No Friends
- ☐ Shallow Friendships

LEGAL HISTORY

- ☐ No Legal Problems
- ☐ Arrest(s) for Substance-Related
- ☐ Court-Ordered Referral/Treatment
- ☐ Jail/Prison
  Times: ____ Total Served: _____
- ☐ Currently on Parole/Probation
- ☐ Arrest(s) Other _____

Describe Last Legal Difficulty: _____

_____

CULTURAL:

Describe your Cultural Identity (e.g., ethnicity): _____

What role does your cultural play in your daily life and how you think about your relationships? _____

_____

Describe any cultural issues that contribute to the problem or concern: _____

_____

RELIGION/FAITH

Religious Affiliation:_____

Church/Synagougue:_____

Pastor/Rabbi/Priests Name: _____

Your Level Of Church Activity: ☐ **Active** ☐ **Inactive**

If 10 represented the highest level of importance and 1 the lowest, approximately what number would you use to rate *church involvement*: _____ Describe your answer: _____

If 10 represented the highest level of importance and 1 the lowest, approximately what number would you use to rate *your faith*: _____ Describe your answer: _____

How is God involved with your life? _____

Do you want a Christian counseling approach? ☐ Yes ☐ No

Do you want the counselor to pray with you? ☐Yes ☐ No

PREVIOUS COUNSELING/TREATMENT:

Have you ever been told that you had an emotional or mental problem?
☐ Yes ☐ No. If "Yes" when and background: _____
_____

EMOTIONAL/PSYCHIATRIC HISTORY

Treatment	Provider	City, State	Duration	Diagnosis	Helpful	Why Stop
Outpatient						
[redacted]						
Inpatient						
[redacted]						

FAMILY PSYCHIATRIC HISTORY:

Treatment	Provider	City, State	Duration	Diagnosis	Helpful?
Outpatient					
[redacted]					
Inpatient					
[redacted]					

HEALTH

Health Rating: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Very Poor

Height:_____ **Weight:**_____ **Date of Last Exam:** _____

In the last 6 months have you: ☐ Gained Weight ☐ Lost Weight: How Much?_____

Describe any physical problems you have that require medication or physical care:

_____

_____

Are you currently under a doctor's care? ☐ Yes ☐ No, If "Yes" please list and describe)_____

_____

If you have had surgeries, please describe: _____

_____

Physician's Name:_____ **Phone:** _____

Address:_____

Check if any of the following that apply to you:

☐Fibromylagia	☐Headaches/Migraines	☐ Fainting
☐Blackouts	☐Muscle Spasms	☐Twitches
☐Cancer	☐Thyroid Problems	☐Tuberculosis
☐Dizziness	☐Bowel Disturbances	☐Head Trauma
☐Sexual pain	☐Erecticle Dysfunction	☐Cardiac Problems
☐Stroke	☐High Blood Pressure	☐Palpitations
☐Binge/Purge	☐Loss of Appetite	☐Tremors
☐Fatigue	☐Insomnia	☐Diabeties
☐Stomach Trouble	☐Nightmares	☐GYN Problems

☐ Other: _____

HEALTH QUESTIONS FOR WOMEN ONLY:

Age of menes: _____ **Were you prepared for menes**? ☐ Yes ☐ No

Have you ever had an abortion? ☐ Yes ☐ No, If "Yes" how many: _____

Describe any complications: _____

_____

Have you ever had a miscarriage? ☐ Yes ☐ No, If "Yes" how many: _____

Describe any complications: _____

_____

Do you experience any of the following with your menstrastion:

irregular? ☐ Yes ☐ No,
pain? ☐ Yes ☐ No
mood or physical changes before your period, PMS? ☐ Yes ☐ No

Describe: _____

_____

MEDICATIONS

If you are currently taking any medication please complete below:

Medication	Frequency	Dose	Date Started	By Whom

Do you use any herbals or supplements? ☐ Yes ☐ No, If "Yes" please list & describe:

_____

_____

SUBSTANCE USE

Family Alcohol/Drug Abuse History:

☐ Father ☐ Mother ☐ Paternal Grandparents ☐ Maternal Grandparents
☐ Paternal Uncles/Aunts ☐ Maternal Uncles/Aunts ☐ Siblings
☐ Children ☐ Spouse/Significant Other ☐ Other: _____

Consequences of Substance Use:

☐ Binges ☐ Hangovers ☐ Withdrawal Symptoms ☐ Sleep Disturbance
☐ Seizures ☐ Blackouts ☐ Tolerance Changes ☐ Overdose
☐ Arrests ☐ Convictions ☐ Assaults ☐ Tremors
☐ Loss of Control in Use

Substance Use History:

Substances Used	Age of First Use	Date of Last Use	Current Use		
			Yes/No	Frequency	Amount
Alcohol					
Amphetamines/Speed					
Barbiturates/Owners					
Caffeine					
Cocaine/Crack Cocaine					
Hallucinogens (e.g., LSD)					
Inhalants (e.g., Glue, Gas)					
Marijuana/Hashish					
Methamphetamine					
Nicotine/Cigarettes					
Painkillers					
Prescription: _____					

DEVELOPMENTAL ISSUES

Birth: ☐ Normal Delivery ☐ Difficult Delivery ☐ Cesarean Delivery
Complications: _____

Infancy: ☐ Feeding Problems ☐ Sleep Problems ☐ Cholic ☐ Toilet Training Issues

Delayed Developmental Milestones (check those that did not occur at expected age):

☐ Sitting
☐ Rolling Over
☐ Standing
☐ Walking
☐ Feeding Self
☐ Speaking Words
☐ Speaking Sentences
☐ Controlling Bladder
☐ Controlling Bowels
☐ Sleeping Alone
☐ Dressing Self
☐ Engaging Peers
☐ Tolerating Separation
☐ Playing Cooperatively
☐ Riding Tricycle
☐ Riding Bicycle

Social Problems

- ☐ Normal Social Interaction
- ☐ Isolates Self
- ☐ Very Shy
- ☐ Alienates Self
- ☐ Inappropriate Sex Play
- ☐ Dominates Others
- ☐ Associates with Acting-Out Peers
- ☐ Other: _____

Emotional/Behavioral Problems:

- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Easily Tearful
- ☐ Poor Attachment
- ☐ Frequent Daydreams
- ☐ Lying
- ☐ Bizarre Behavior
- ☐ Self-Inurious Acts
- ☐ Stealing
- ☐ Vandelism
- ☐ Repeat Words of Others
- ☐ Not Trustworthy
- ☐ Poor Concentration
- ☐ Immature
- ☐ Often Sad
- ☐ Angry/Hostile
- ☐ Indecisive
- ☐ Impulsive
- ☐ Fire-Setting
- ☐ Disobedient/Rebellious
- ☐ Distrustful
- ☐ Worrier
- ☐ Stutering
- ☐ Easily Distracted
- ☐ Vomiting/Binge Eating
- ☐ Violent Temper
- ☐ Self-Inurious Threats
- ☐ Animal Cruelty
- ☐ Assualts Others
- ☐ Oppositional

Intellectual/Academic Problems

- ☐ Normal Intelligence
- ☐ High Intelligence
- ☐ Low Intelligence
- ☐ Learning Disorders: (specify): _____
- ☐ Authority Conflicts
- ☐ Attention Problems
- ☐ Underachieving

SEXUAL HISTORY

Have you ever had same-sex attraction: ☐ Yes ☐ No

Orientation:

- ☐ Heterosexual Orientation
- ☐ Bisexual Orientation
- ☐ Homosexual Orientation
- ☐ Undetermined Orientation

Identity:

- ☐ Heterosexual Identity
- ☐ Homosexual Identity
- ☐ Bisexual Identity

Age of first sexual (not just intercourse) experience: _____

Mark any behaviors that you have or currently engage in: (check all that apply)

- ☐ Excessive Fantasy
- ☐ Same Sex Encounters
- ☐ Sexual Massages
- ☐ Pornography
- ☐ Swing Sex
- ☐ Phone/Cyber Sex
- ☐ Unsafe Sex Practices
- ☐ Promiscuity
- ☐ Paying for Sex
- ☐ Exhibitionsim Sex
- ☐ Anonymous Sex
- ☐ Sex with Minor
- ☐ Bisexual Encounters
- ☐ "Gentlemen" Clubs
- ☐ Voyeruistic Sex
- ☐ Pain Sex (S&M Like)
- ☐ Sex with Objects
- ☐ Excessive Masturbation

Do you believe you are out of control with sex? ☐ Yes ☐ No

List any genital infections and sexually transmitted diseases that you have had or currently have:

Sexually Transmitted Infections (STIs)	Approximate Dates	Treatments and Results

PRESENTING PROBLEM(S)

Briefly describe the main problem which prompted you to seeking counseling at this time:_____

_____

How long have you faced these problems?_____

Have there been times when the problems got better or disappeared? ☐ Yes ☐ No

If so when? _____

What do you think helped?_____

_____

Were there times when the problem was especially bad? ☐ Yes ☐ No

When?_____

What made it bad?_____

_____

_____

Are there are other people who play a role in:

☐**Causing your problem**? Who: _____

☐**Helping your problem**? Who: _____

Briefly explain:_____

_____

Please check any of the following that are currently troubling you. Put *two* checks by those items which are most important. You may add any comments you would like:

Situational			
☐Academic	☐Adultery	☐Divorce	
☐Family Violence	☐Finances	☐Occupational	☐Parenting
☐Rejection	☐Religious/Spiritual	☐Same Sex Attraction	☐Single Parenting
		☐Spouse Problems	☐

Physical			
☐Back Problem	☐Blackouts	☐Bowel Issues	☐Breathing Problems
☐ Chest Pain	☐Cognitions	☐Dizziness	☐Dry Mouth
☐Exhausation	☐Fainting	☐Fatigue	☐Impotence
☐Headaches	☐Impotence	☐Muscle Tension	☐Numbness
☐Pain	☐Relaxation Issues	☐Sleep Problems	☐Sweating Issues
☐Tremors	☐Twitches	☐Tension	☐Vomiting

Behavior Problems or Issues			
☐Abortion	☐Adjustment	☐Adoption	☐Aggression
☐Assertiveness	☐Child Abuse	☐Communication	☐Crying
☐Cutting	☐Discipline/Self	☐Drink Too Much	☐Eating/Too Much
☐Eating/Too Little	☐Failure	☐Family Conflict	☐Habit
☐Honesty	☐Impulsive	☐Overactivity	☐Perfectionism
☐Phobia	☐Pornography	☐ Pride	☐Procrastination
☐Rape	☐Rebellion	☐Risk Taking	☐Rituals
☐Sex	☐Shy	☐Substance Abuse	☐Tics
☐Trust	☐Underactivity	☐Withdrawal	☐Work Too Hard

Cognitve Problems or Issues			
☐Attention	☐Concentration	☐Confusion	☐Homicidal Ideation
☐Judgment	☐Memory	☐Obsessions	☐Suicidal Ideation

Feelings				
☐Agitated	☐Anger	☐Annoyed	☐Anxiety	☐Apathy
☐Bitterness	☐Bored	☐Excited	☐Bored	☐Bored
☐Content	☐Depressed	☐Energetic	☐Envious	☐Forgivenness
☐Frustration	☐Furious	☐Grief	☐Guilt	☐Happy
☐Hopeful	☐Hopeless	☐Irritability	☐Jealous	☐Loneliness
☐Loss Interest	☐Loss Pleasure	☐Lust	☐Panicky	☐Regretful
☐Restless	☐Sad	☐Stress	☐Suspicousness	☐Unhappy