PSYCHOTHERAPY INTEGRAL INTAKE

Name ____
Date ___________
Home # ________________________
Cell # __________________________
Work # _________________________
Address ____________________________________ City_________________
Zip_______________
Birthdate _____________ Age_____
Email____

Gender □M □F □TS/ Height _____/ Weight _____ lbs/

Relationship: □Single □Dating □Involved □Living together □Married
□Separated □Divorced □Widow

Sexual Orientation: □Straight □Bisexual □Gay/Lesbian □Uncertain

PRELIMINARY ISSUES AND PREVIOUS THERAPY

What is the primary concern or problem for which you are seeking help?

____
____
____
____

What makes it better? What makes it worse?

____
____
____
____

Are there any ***immediate*** challenges or issues that need our attention?
□Yes □No If yes, please describe.

____
____
____
____

Have you had previous counseling or psychotherapy? ☐Yes ☐No. From when to when? With whom?

What was most helpful about your previous therapy?

What was least helpful about your previous therapy?

What did you learn about yourself through your previous therapy?

What do you expect from me and our work together?

EXPERIENCE: Individual-Interior

What are your strengths?

What are your weaknesses?

How would you describe your general mood/feelings?

What emotions do you most often feel, and what emotions do you feel most strongly?

What are the ways in which you care for, and comfort yourself when you feel distressed?

How do you deal with strong emotions in yourself?

How do you respond to stressful situations and other problems?

Are you aware of recurring images or thoughts (either while awake or in dreams)? ☐Yes ☐No If yes, please describe.

Have you *ever* attempted to seriously harm or kill yourself, or anyone else? ☐Yes ☐No If yes, please describe.

Are you *presently* experiencing suicidal thoughts? ☐Yes ☐No If yes, please describe.

Has anyone in your family ever attempted, or committed suicide? ☐Yes ☐No
If yes, please describe.

Have there been any serious illnesses, births, deaths, or other losses or changes in your family that have affected you? ☐Yes ☐No If yes, please describe.

What is your earliest memory?

What is your happiest memory?

What is your most painful memory?

Where in your body do you feel stress (shoulders, back, stomach, heart, etc.)?

____

____

Do you have ways in which you express yourself creatively and/or artistically? ☐Yes ☐No If yes, please describe.

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____

Describe your leisure time (hobbies/enjoyment).

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____

____

____

Have you ever been a victim of, or witnessed, verbal, emotional, physical, and/or sexual abuse? ☐Yes ☐No If yes, please describe.

____

____

____

____

In general, how satisfied are you with your life?

Not at all 1 2 3 4 5 6 7 Very

In general, how do you feel about yourself (self-esteem)?

Not at all 1 2 3 4 5 6 7 Very

In general, how much control do you feel you have over your life and how you feel?

Not at all 1 2 3 4 5 6 7 Very

Please mark any of the following which you experience presently or have had sometimes in the recent past:

☐ Angry
☐ Lonely
☐ Anxious/worried
☐ Sad
☐ Afraid
☐ Shameful/guilty

- □ Jealous
- □ Grateful/thankful
- □ Excited
- □ Hopeful
- □ Difficulty concentrating
- □ Feeling hopeless
- □ Thoughts racing through your head
- □ Happy
- □ Sexual/erotic
- □ Energetic
- □ Relaxed/peaceful
- □ Poor or excessive appetite
- □ Needing less sleep than normal
- □ Desire to harm yourself
- □ Little interest or pleasure in doing things
- □ Having much more energy than normal
- □ Thoughts that you would be better off dead
- □ Hearing or seeing things not actually there
- □ Thoughts that seem strange but that you can't seem to stop
- □ Fear that someone is trying to harm you
- □other emotions, thoughts, and/or feelings you often feel:

____
____
____
____

BEHAVIOR: Individual-Exterior

Please list any medications you are presently taking (dosage/amount and what the medication is for).

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____
____
____

Do you have a primary care physician? □Yes □No If yes, please indicate name, address & phone number

____
____

When was your last physical? _______________ Were there any noteworthy results or aspects that concern and/or worry you (diseases, blood pressure, cholesterol, etc.)?

____
____
____
____

Have you ever suffered a head injury or other serious injury? ☐Yes ☐No If yes, please describe.

____
____
____
____

What other significant medical problems have you experienced or are you experiencing now?

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____
____
____

Please mark any of the following behaviors, or bodily feelings that are true of you:

☐ Drink too much, please describe frequency & quantity:

____
____

☐ Use recreational drugs, please describe frequency & quantity:

____
____

☐ Eat too little, please describe frequency & quantity:

____
____

☐ Eat too much, please describe frequency & quantity:____
____

☐ Neglect self and your own needs
☐ Neglect friends and family
☐ Lose your temper
☐ Headaches
☐ Dizziness
☐ Jitters
☐ Tingling/numbness
☐ Blackouts
☐ Feel depressed/ pessimistic
☐ Think about suicide
☐ Have difficulty concentrating
☐ Menstrual problems
☐ Heart tremors
☐ Sexual pre-occupations
☐ Excessive tiredness
☐ Hear or see things not actually there
☐ Seem to not have control over some behaviors
☐ Difficulty being kind and loving to yourself
☐ Act in ways that end up hurting yourself or others
☐ Spend more money than you can afford

Any other behaviors or bodily feelings you experience:

In general, how would you rate your physical health?
Very unhealthy 1 2 3 4 5 6 7 Very healthy

Sleeping patterns (When do you go to bed, fall asleep, how many hours per 24 hrs do you sleep, do you sleep straight through or do you wake up during sleep time, etc.?)

Do you feel rested upon waking? □Yes □No If no, please describe.

Describe your usual eating habits (types of food, frequency and quantity).

Do you take vitamins and other nutritional supplements? □Yes □No If yes, please describe.

Do you engage in some form of exercise (aerobic and/or strength building)? □Yes □No If yes, please describe.

Do you have any communication impairments (sight, hearing, speech)?

□Yes □No If yes, please describe frequency & intensity.

CULTURE: Collective-Interior

Describe your relationships, including friends, family, and co-workers.

What is important and meaningful to you (what matters the most to you)?

In general, how satisfied are you with your friendships and other relationships? Not at all 1 2 3 4 5 6 7 Very

In general, how comfortable are you in social situations?
Not at all 1 2 3 4 5 6 7 Very

In general, how satisfied are you with your religion/spirituality?
Not at all 1 2 3 4 5 6 7 Very

Which emotions were encouraged, or commonly expressed in your ***family of origin*** (family you grew up with)?

Which emotions were discouraged, or not allowed in your ***family of origin***?

What emotions are most comfortable for you now?

What emotions are most uncomfortable for you now?

How do you identify yourself ethnically? How important is your ethnic culture to you?

How did your ***family of origin*** express love and care?

How does your ***current family*** express love and care?

How did your ***family of origin*** express disapproval?

How does your ***current family*** express disapproval?

Have you ever been □ married or in a □ long term living situation? □Yes □No If yes, please describe the ending of the □marriage/ long term living situation.

Are you currently in a □ romantic □ love relationship(s)? □Yes □No If yes, please describe.

Are you sexually active? □Yes □Non. If yes, how satisfied are you with your sex life?

What beliefs do you have about sex? How important is sex to you?

Do you have a religious/spiritual affiliation and/or practice? □Yes □No
If yes, please describe.

What beliefs do you have about religion/spirituality? How important to you are those beliefs?

What are some of your most important morals? How important to you are those morals?

Do you participate in any political, civic, volunteer group? □Yes □No, If yes, how involved are you?

Are you involved with any cultural activities or institutions?
□Yes □No If yes, please describe.

Have you ever been a victim of any form of prejudice or discrimination (racial, gender, etc.), or felt that you were disadvantaged in terms of power and privilege in society? □Yes □No If yes, please describe.

SOCIAL SYSTEMS: Collective-Exterior

Describe your current *physical* home environment (layout, privacy, noise, A/C, heating, well-lit, etc.?).

Describe your neighborhood. Is it □safe □dangerous □nice □unpleasant □quiet □loud, etc.?

Describe your current *social* home environment. How would an outside observer describe how you get along with those who live with you?.

Do you have pets? □Yes □No If yes, what kind and how important are they to you?

Have you served in the military? □Yes □No If yes, please describe.

Are you currently involved in a custody dispute? □Yes □No If yes, please describe.

Have you had any involvement with the legal system (incarceration, probation, etc.)? □Yes □No If yes, please describe.

What aspects of your life are stressful to you? Please describe.

What sort of support system do you have (friends, family, religious community, etc.)?

List your ***family of origin*** (family you grew up with), beginning with the oldest, include parents and yourself.
Name, Age, Gender, Alive/deceased, Relationship: mom/dad, biological, step, half.

What is your educational background?

What is your occupation?

How satisfied are you with your work?

Not at all 1 2 3 4 5 6 7 Very

How satisfied are you with your standard of living?

Not at all 1 2 3 4 5 6 7 Very

Are money and financial matters significant stressors in your life? (please expand).

List the people you currently live with, from oldest to youngest including yourself.

Name, Age, Gender, Alive/deceased, Relationship: mom/dad, biological, step, half.

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____
____
____
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____
____

Describe any family history of mental illness.

____
____
____
____

Please mark any of the following for which you experience, or did experience difficulty. Please also indicate, to the right of the problem, your approximate age when the difficulty or problem occurred:

- ☐ nursing and/or eating _____
- ☐ toilet training _____
- ☐ crawling or walking _____
- ☐ talking _____
- ☐ cruelty to animals or people _____
- ☐ serious illnesses or injuries _____
- ☐ academic problems _____
- ☐ social problems _____
- ☐ moves or other family stresses _____
- ☐ fitting into social groups _____
- ☐ any problems with sexual maturation _____
- ☐ any existential dilemmas _____
- ☐ abuse (emotional, physical, or sexual) _____
- ☐ going to school/ separating from caregivers _____
- ☐ being made fun of or joked about at school, home, or elsewhere _____
- ☐ self-destructiveness (risky sex, drug use, excessive risk-taking, etc.) _____
- ☐ standing up for what you believe in when it differs from your peers' views _____
- ☐ making important decisions, especially when they differ from social norms _____

The following is a list of various parts, selves, aspects or *subpersonalities* that many people notice within themselves in certain situations. Please mark any of the following that you have experienced difficulty or problems with. Often, it is only after the fact that we notice that we were behaving, thinking, or feeling in a problematic manner. Please indicate to its right the situation or context in which you noticed this part of yourself.

□ irresponsible child

___

□ critical parent, dominating, controlling, "top dog"

___

□ pleaser, submissive, "underdog"

___

□ overly critical (towards self)

___

□ overly judgmental (towards others)

___

□ unworthy, not-good-enough, shameful, guilty

___

□ grandiose, better-than

___

□ other, please describe

___

Is there anything else you want me to know about, or think it would be useful for me to know to better help you? (Use the back of the page if you need to.)

___