



Machiel P. Klerk Counseling

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

Referral Source \_\_\_\_\_

**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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



What was most helpful about your previous therapy?

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What was least helpful about your previous therapy?

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What did you learn about yourself through your previous therapy?

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What do you expect from me and our work together?

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**EXPERIENCE: Individual-Interior**

What are your strengths?

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What are your weaknesses?

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How would you describe your general mood/feelings?

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

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

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How do you deal with strong emotions in yourself?

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How do you respond to stressful situations and other problems?

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

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

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

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

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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.

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What is your earliest memory?

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What is your happiest memory?

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What is your most painful memory?

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

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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.

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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
- Jealous
- Grateful/thankful
- Excited
- Hopeful
- Difficulty concentrating
- Feeling hopeless
- Thoughts racing through your head
- 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:

- Sad
- Afraid
- Shameful/guilty
- Happy
- Sexual/erotic
- Energetic
- Relaxed/peaceful
- Poor or excessive appetite
- Needing less sleep than normal
- Desire to harm yourself

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**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

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

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

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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:

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Use recreational drugs, please describe frequency & quantity:

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Eat too little, please describe frequency & quantity:

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Eat too much, please describe frequency & quantity:

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- Neglect self and your own needs
- Neglect friends and family
- Lose your temper
- Headaches
- Dizziness
- Jitters
- Tingling/numbness
- Blackouts
- 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
- 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

Any other behaviors or bodily feelings you experience:

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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.?)

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

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

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

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

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Do you have any communication impairments (sight, hearing, speech)?  
Yes No If yes, please describe frequency & intensity.

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CULTURE: Collective-Interior

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

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

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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)?

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

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What emotions are most comfortable for you now?

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What emotions are most uncomfortable for you now?

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

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How did your family of origin express love and care?

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How does your current family express love and care?

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How did your family of origin express disapproval?

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How does your current family express disapproval?

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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.

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

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

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

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

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

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

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

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Are you involved with any cultural activities or institutions?

Yes No If yes, please describe.

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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.

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**SOCIAL SYSTEMS: Collective-Exterior**

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

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

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

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

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

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

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

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

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

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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.

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What is your educational background?

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What is your occupation?

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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).

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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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Describe any family history of mental illness.

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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:

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

