



INTAKE INFORMATION FORM

Welcome to Pathways Professional Counseling, a Family Ministry of Alabama Baptist Children's Homes. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us better understand your situation. Please note that the information is confidential and will not be released to anyone without your written permission.

Name: _____ Date: _____

Adult strength scale. Please mark with X the areas below that apply to you:

Home

- | | | | | | | | | | | |
|----------------------------------|-----|--------|-----|---------------|-----|-------------|-----|-----------|-----|-----|
| I feel part of the family | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I get along with my spouse | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I am physically healthy | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I have an enjoyable social life | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I feel accepted by others | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I am a good father/mother | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I participate in decision making | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |

Work

- | | | | | | | | | | | |
|----------------------------------|-----|--------|-----|---------------|-----|-------------|-----|-----------|-----|-----|
| I get to work on time | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I get along with my co-workers | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I am respected by my co-workers | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I am respected by my supervisors | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I have realistic career goals | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |
| I balance home and work | ___ | seldom | ___ | just a little | ___ | pretty much | ___ | very much | ___ | n/a |

Emotional

I cope well with frustration _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I cope well with disappointment _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I am satisfied with life _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I accept responsibility for my mistakes _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I drink alcohol responsibly _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I can take constructive criticism _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I think before I act _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

Social

I make and keep friends _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I'm open to new ideas _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I am considerate of others _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I stand up for myself _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I show leadership _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I am able to compromise _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I'm comfortable around others _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I get along with others _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

Attention

I cope with external distraction _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I maintain attention to tasks _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I follow through on tasks _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

I am able to compromise _____ seldom _____ just a little _____ pretty much _____ very much _____ n/a

Problems you are struggling with. *Please mark with X those that apply to you.*

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parent-child conflict (self) |
| <input type="checkbox"/> Anxiety or panic attacks | <input type="checkbox"/> Parent-child conflict (spouse) |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Marital/relationship problems |
| <input type="checkbox"/> Suicidal actions | <input type="checkbox"/> Brother/sister problems |
| <input type="checkbox"/> Remarried family problems | <input type="checkbox"/> Anger/temper problems |
| <input type="checkbox"/> Violence in family-actual or threatened | <input type="checkbox"/> Job/school problem |
| <input type="checkbox"/> Sexual problem | <input type="checkbox"/> Sexual Abuse - Adult/Child |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> Low self - esteem |
| <input type="checkbox"/> Legal problems | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Compulsive gambling | <input type="checkbox"/> Major losses/difficult changes |
| <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Communication problems |
| <input type="checkbox"/> Alcohol/drugs: <i>Please include history, current use, as well as type, amount, and frequency.</i> | |

Other: *Please describe in space provided.*

Additional comments if necessary:

Problems with coping. *Please mark with X those which apply to you.*

- | | |
|--|---|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Gaining weight (specify _____) |
| <input type="checkbox"/> Waking in the middle of the night | <input type="checkbox"/> Losing weight (specify _____) |
| <input type="checkbox"/> Waking too early | <input type="checkbox"/> Not hungry or not eating |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Throwing up after eating |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Feeling sick to my stomach |
| <input type="checkbox"/> Moody or crying more than usual | <input type="checkbox"/> Constipation or diarrhea |
| <input type="checkbox"/> Difficulties concentrating | <input type="checkbox"/> Feeling guilty, worthless, or hopeless |
| <input type="checkbox"/> Problems remembering things | <input type="checkbox"/> Fatigue/low energy |
| <input type="checkbox"/> Withdrawing from others | <input type="checkbox"/> Hyper/too much energy |
| <input type="checkbox"/> Repeated actions I can't stop | <input type="checkbox"/> Loss of interest in things |
| <input type="checkbox"/> Can't stop washing hands/body, counting, or checking things | |
| <input type="checkbox"/> Disturbing thoughts I can't stop | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> People picking on me | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Self-harm | <input type="checkbox"/> I hear things that are not real |
| <input type="checkbox"/> I cut myself | <input type="checkbox"/> I see things that are not real |
| <input type="checkbox"/> I burn myself | <input type="checkbox"/> I smell things that are not real |
| <input type="checkbox"/> I hit myself | <input type="checkbox"/> I feel things that are not real |
| <input type="checkbox"/> Other <i>Please describe in space provided.</i> | |

List any previous suicide attempts. *If none, write None*

When / method

List previous inpatient psychiatric and/or drug-alcohol rehab hospitalization. *If none, write None*

Dates of hospitalization / reason

Previous or current counseling. *If none, write None*

Therapist or agency / dates of counseling / focus of sessions

What was helpful and what was not helpful about your previous/current counseling experience?

Current medication you regularly take. Please include prescription, over the counter, and any herbal remedies. *If none, write None*

Name of medication / dosage / how often / day

Are you allergic to any drugs? *Please list.*

Are you currently on probation? Have you ever been in jail or prison? *If yes, please explain:*

Family Information. *Please list the people that you currently live with:*

Name / relationship / age

Current marriage: Name of spouse / date of marriage

Previous marriages: Name of ex-spouse / length of marriage

Previous marriages of your current spouse: Name of ex-spouse / length of marriage

Do you have other children not living with you? *If yes, please give names and ages:*

Does your family have any psychiatric or substance abuse history? *Please list:*

Does your family have a history of major health problems? *Please list:*

What is your relationship like with your parents / siblings?

Please list family, friends, support groups and community groups that are helpful to you.

Have you ever been in the military? *If yes, please provide details below:*

What is your highest level of education? _____

Current Functioning

Please place an **X** on the following scale to indicate how well you are coping at the present time.
100% means that you are coping the best that you can, considering your situation.

___0% ___10% ___20% ___30% ___40% ___50% ___60% ___70% ___80% ___90% ___100%

Your Goals in Counseling

Goals are important in counseling. They provide us with a focus and direction that helps us help you. Please list the goals you hope to address and achieve in counseling. Please be as specific as possible.

- 1. _____
- 2. _____
- 3. _____

By including my initials and last four digits of my social security number, I hereby confirm I am above 18 years old and this constitutes my electronic signature.

Full Name: _____

Initials: _____ Date: _____

Last Four Digits of Social Security Number: _____