Smith Counseling Services
714 E. Edison Ave. Suite B, Sunnyside, WA
98944 (509) 515-0420

Client Name: _____ Date of Birth: _____ Age: _____
Intake Date: _____

Please fill out the information provided in these pages to ensure your therapist has the appropriate information regarding your care.

What are the current issues that bring you to counseling?

What would you like to get out of counseling?

Please check any of the following that describe how you have been feeling lately:

□ Depression	□ Anxiety	□ Sleep changes	□ Appetite Changes	□ Anger	□ Fear
□ Shame	□ Worthless	□ Tearful	□ Moodiness	□ Hopeless	□ Helpless
□ Aggressive	□ Jealous	□ Sad	□ Irritable	□ Confused	□ Guilt

□ Suicidal thoughts □ Homicidal thoughts (harm to others)

Current Stressors:	**None**	**Mild Stress**	**Moderate**	**Severe stress**
Family	□	□	□	□
Friends	□	□	□	□
Relationships	□	□	□	□
Educational	□	□	□	□
Economic	□	□	□	□
Occupational	□	□	□	□
Housing	□	□	□	□
Legal	□	□	□	□
Health	□	□	□	□

What are your strengths and weaknesses?
Strengths:

Weaknesses:

Smith Counseling Services

Abuse/Trauma History- Circle none if - NONE

Please indicate if you have a history of verbal/sexual/physical abuse:
Type of abuse: _____ Age of abuse: _____ Results: _____
Type of abuse: _____ Age of abuse: _____ Results: _____

Please indicate if you have any history of having experienced a traumatic event:
Type of Trauma: _____ Age at event: _____ Results: _____
Type of Trauma: _____ Age at event: _____ Results: _____

Substance Use History- Circle if None – NONE
If yes, please specify.
Please fill out the information below regarding any history of substance use:

Substance Used	Age of First Use	Age of last use	How was it used?	Amount per day	Days per Month
Amphetamines/Speed	_____	_____	_____	_____	_____
Barbiturates/Downers	_____	_____	_____	_____	_____
Opiates	_____	_____	_____	_____	_____
Cocaine Psychedelics (ex. LSD, Ecstasy, Bath Salts, etc.)	_____	_____	_____	_____	_____
Inhalants (ex. glue, etc.)	_____	_____	_____	_____	_____
Cannabis/Marijuana/Hashish	_____	_____	_____	_____	_____
Benzodiazepines	_____	_____	_____	_____	_____
PCP	_____	_____	_____	_____	_____
Synthetics (K2 etc.)	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

Alcohol Use: Circle if None –NONE

If yes, please specify.
Type of Alcohol:_____ How much?_____ How often do you drink this? _____
Type of Alcohol:_____ How much?_____ How often do you drink this? _____
Type of Alcohol:_____ How much?_____ How often do you drink this? _____

Substance/Alcohol Treatment: Circle if None- NONE

Type of treatment: Inpatient Outpatient
Location/Name of Tx Center: _____ Dates started and ended: _____
Location/Name of Tx Center: _____ Dates Started and ended: _____

Psychiatric History

Inpatient Psychiatric History Circle if None –NONE

If yes, please specify treatment history.

Hospital	***Voluntary***	***Reason for admission***	***Age***	***Outcome***
_____	Y N	_____	_____	_____
_____	Y N	_____	_____	_____

Outpatient Counseling History Circle if None –NONE

If yes, please specify treatment history.

Reason for seeking services	Age at beginning	Age at end	Outcome	Provider
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Suicide/Self-Harm/Homicide

Have you ever tried to harm or kill yourself?	YES	NO
Was your intent to die?	YES	NO
How many times have you tried to harm or kill yourself? _____		
Have you ever engaged in self-mutilation (cutting/burning self, etc.)	YES	NO
Have you ever tried to harm or kill someone else?	YES	NO
Are you currently having thoughts of hurting yourself?	YES	NO
Are you currently having thoughts of hurting someone else?	YES	NO
Have you engaged in any self-harm behavior in the last month?	YES	NO

Most Recent Suicide Attempt

Date of Attempt (Month/Year):_____

Method: _____

Outcome (hospitalization, ER, etc.)_____

Violence History

Do you have a history of violent behavior? YES NO

If yes, please explain:

_____

Family Psychiatric History

Do you have any family members with a history of mental health issues?

Family Member	Mental Health Issues
_____	_____
_____	_____

Legal Issues

Current Legal Issues? □ Yes □ No If Yes: □ Child Custody □ Divorce □ CPS □ Criminal

Are you under supervision of the Dept of Corrections? □ Yes □ No

Medical History

Who is your primary physician? _____ Phone number: _____

What medications are you currently taking? (Please list all medications)

Medication	Dose	Reason for taking	Prescribing Doctor	How long?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have any of the following ongoing health concerns? (check all that apply):

☐ **No problems**

□Fibromyalgia	□Iron deficiency	□ Allergies	□ Anemia	□Stroke/TIA
□Arthritis	□Asthma	□Back problems	□ Cancer	□Cataracts
□Chickenpox (as a child)	□ Insomnia	□ Chronic Bronchitis	□COPD(Emphysema)	□Diabetes
□Diverticulitis	□Fainting spells/Passing out	□ Gall Bladder disease	□Gastritis or Ulcer	□Glaucoma
□Gout	□Hearing Loss	□Heart Disease	□Heart Valve problems	□Hepatitis
□HIV	□Hypertension	□Hypotension	□High Cholesterol	□Liver Disease
□Inflammatory Bowel Disease		□Kidney disease	□Kidney Stones	
□Lupus	□Migraine Headaches	□Multiple Sclerosis	□Obesity/Overweight	
□Parkinson's' Disease	□Polyps	□Seizures	□Sleep Apnea	
□Low Testosterone	□Thyroid problems	□Tuberculosis	□ Other:_____	

Social History

Developmental and Educational

While pregnant with you, did your mother have problems with any of the following?

☐ Use of drugs or alcohol □ Difficult pregnancy □ Problems with delivery □ Other: _____

☐ None of these □ Unknown

Did you have any complications after your birth? □ YES □ NO If so, what: _____

Did you have any of the following delays or difficulties?

□ Walking □ Sleeping Alone

□ Talking □ Making friends

□ Toilet Training □ Being Away from Parent □None of these

Which options best describe your childhood home atmosphere?

□ Normal □ Frequent Moving □ Single Parent Home
□ Supportive □ Financial Difficulties □ Lack of parental involvement
□ Parental Fighting □ Parenting Violence Other:_____

Which of the following challenges were experienced during your childhood?

□ Tantrums □ Enuresis (bet wetting) □ Encopresis (bowel incontinence)
□ Running away from home □Fighting □Stealing □Property damage □ Fire setting
□Animal cruelty □Separation Anxiety □NONE

Which of the following best describe problems you had in school?

□ Fighting □ Truancy □ School Phobia □ Detentions □ Suspensions
□ Expulsions □ School refusal □ Repetition of grades □ Special education □ Remedial classes
□ NONE

Did you have additional schooling outside of the standard classroom? (Check all that apply)

□ Speech classes □ Accommodations □ Tutoring □ Other_____ □ NONE

Please select your highest level of education:

□ Less than high school □ High School/GED □ Some college □ 2-year degree □ 4-year degree
□ Technical school degree □ Graduated Professional Degree (MA, Ph.D., etc.)

If you have any further information regarding your development or educational history, please do so in the space provided:

General Social History

Which option(s) best describe your social support situation? (Check all that apply)

□ Supportive social network □ Few Friends □ Substance-use based friends □ No friends
□ Distant from family of origin □ Family Conflict □ Other:_____

What is your current marital status?

□ Single, never married/youth □ Married/Permanent partnership □ Divorced □Widowed □Separated

What is the satisfaction level of your current relationship?

□ Very satisfied □ Satisfied □ Somewhat satisfied □ Dissatisfied □ Not Applicable

What is your current living situation?

□ Rent (house/apartment) □ Own (house/condo) □ Youth/live w/ Parents/Caregiver □ Homeless □ Foster Care

What are your current Hobbies or Interests:

Who currently lives with you?

Name	Age	Relationship	Name	Age	Relationship
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

Do you currently participate in spiritual activities? □ YES □ NO

What activities: _____

Where do you participate? _____

What is your current occupational status?

□ Employed Full-time □ Employed part-time □ Temporary/seasonal employment □ Full-time student
□ Part-time student □ Homemaker □ Unemployed (seeking work)
□ Unemployed(not seeking work) □ Retired □ Disability

If in school, which school and what is your current grade level? _____

If working, what/where is your current occupation? _____

How long have you worked there? _____

Do you have any work-related concerns? _____

Have you served in the military? □ Yes □ No

Do you have an Advanced Directive? □ No □ Yes □ Living Will □ Power of Attorney If so, please provide a copy.

*An **advance directive** is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.*

Additional Information

What other information would you like to share with your therapist prior to your appointment?

CLINICIAN ONLY:

Clinical Assessment Outcome based on symptoms and report by individual. Provisional Diagnosis:

_____

_____

_____

_____