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Stone Counseling & Consulting Services, LLC

Rebecca L. Stone, M.A., LMHC

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INTAKE QUESTIONNAIRE

The information supplied below is for the use of your counselor and will be kept confidential. Please help your counselor by answering each question as fully and honestly as you can prior to your first counseling session. Adolescents should complete this form on their own and seek assistance from their parent/guardian when needed.

PERSONAL IDENTIFICATION DATA

Today's Date: ____/____/_____ **How did you hear about me?** _____

Client Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____

Nickname/Preferred Name: _____

Client Date of Birth: ____/____/_____ **Client Age:** _____

Parent(s)/Guardian(s) Name(s) (for an adolescent)**:** _____

CONTACT INFORMATION

Home Address: _____

OK to send mail here? ☐ Yes ☐ No

Phone: Home (____) ____-_____ **Calls OK?** ☐ Yes ☐ No **Voicemail OK?** ☐ Yes ☐ No

Cell (____) ____-_____ **Calls OK?** ☐ Yes ☐ No **Voicemail OK?** ☐ Yes ☐ No

Work (____) ____-_____ **Calls OK?** ☐ Yes ☐ No **Voicemail OK?** ☐ Yes ☐ No

Email address: _____ **Emails OK?** ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Phone: Home (____) ____-_____ **Cell** (____) ____-_____ **Work** (____) ____-_____

Name: _____ **Relationship:** _____

Phone: Home (____) ____-_____ **Cell** (____) ____-_____ **Work** (____) ____-_____

PERSONAL HISTORY

What sex were you assigned at birth? ☐ Female ☐ Male ☐ Intersex

What is your gender identity? ☐ Woman ☐ Man ☐ Transgender F-M ☐ Transgender M-F

☐ Self-identify (specify): _____

What is your sexual orientation? ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer

☐ Questioning ☐ Pansexual ☐ Asexual ☐ Self-identify (specify): _____

What is your race/ethnicity? ☐ African American/Black ☐ American Indian or Alaskan Native

☐ Asian American/Asian ☐ Hispanic/Latino/a ☐ Native Hawaiian or Pacific Islander

☐ Multi-racial ☐ White ☐ Self-identify (specify): _____

What is your country of origin? _____

If different than the USA, what is your immigration status? _____

What is your religious/spiritual preference? ☐ Agnostic ☐ Atheist ☐ Buddhist ☐ Catholic

☐ Christian ☐ Hindu ☐ Jewish ☐ Muslim ☐ No preference ☐ Spiritual but not religious

☐ None ☐ Self-identify (specify): _____

To what extent does your religious/spiritual preference play an important role in your life?

☐ Very important ☐ Important ☐ Neutral ☐ Unimportant ☐ Very unimportant

Which of the following words do you believe best describe you? (check all that apply)

☐ Active	☐ Hard-working	☐ Lonely	☐ Self-conscious
☐ Ambitious	☐ Imaginative	☐ Moody	☐ Sensitive
☐ Calm	☐ Impatient	☐ Nervous	☐ Serious
☐ Easygoing	☐ Impulsive	☐ Often-down	☐ Shy
☐ Excitable	☐ Indifferent	☐ Passive	☐ Strategic
☐ Extrovert	☐ Introvert	☐ Persistent	☐ Submissive
☐ Good-natured	☐ Leader	☐ Quiet	
☐ Hardened	☐ Likeable	☐ Self-confident	

List 3-5 words that <u>other people</u> would use to describe you: _____

_____

Are you a veteran? ☐ Yes ☐ No **If yes, have you been in active war zone?** ☐ Yes ☐ No

PRESENTING CONCERNS

What concern(s) led you to seek counseling? _____

_____

_____

Why have you decided to come to counseling now? _____

_____

_____

What have you tried thus far to address the concern(s)?_____

_____

_____

What would you like to accomplish through counseling?_____

_____

_____

Have you previously experienced this concern? ☐ Yes ☐ No

If yes, have you previously sought treatment for this concern? ☐ Yes ☐ No

If yes, who did you see? ☐ Therapist ☐ Psychiatrist ☐ Primary Care Physician ☐ Other: _____

Describe the treatment you received: _____

_____

_____

EDUCATIONAL HISTORY

Are you currently attending school/college? ☐ Yes ☐ No

_____

If yes, which school and what is your year and major (if applicable)? _____

_____

What is your last year of school completed?

Grade school: ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College (undergraduate): ☐ 1 ☐ 2 ☐ 3 ☐ 4+ **College (graduate):** ☐ 1 ☐ 2 ☐ 3 ☐ 4+

What is your highest degree level completed? ☐ High school diploma ☐ GED

☐ Professional certificate ☐ Some college ☐ Associate's degree ☐ Bachelor's degree

☐ Master's degree ☐ Doctoral degree ☐ Other (specify): _____

If you received a college degree, what is your degree major/area of specialization? _____

_____

Describe your involvement in school: _____

Describe any significant events that occurred during school/college: _____

_____

Are/were you in any special education/exceptional education program? ☐ Yes ☐ No

If yes, what kind of program?

☐ Physically Impaired
☐ Hospital/Homebound
☐ Language Impaired
☐ Emotionally Handicapped
☐ Severely Emotionally Disturbed
☐ Hard of Hearing/Deaf
☐ Vision Impaired
☐ Deaf/ Blind
☐ Occupational Therapy
☐ Speech Therapy
☐ Learning Disability
☐ Gifted
☐ Autistic
☐ Educable Mentally Handicapped

Do/did you have an Individualized Educational Plan (IEP)? ☐ Yes ☐ No

Do/did you have any disciplinary problems in school? ☐ Yes ☐ No

If yes, check all the following that apply: ☐ Suspension ☐ Expulsion ☐ Referrals ☐ Alternative schools (e.g., Excel) ☐ Other (describe): _____

How would you rate your overall school experience on a scale from 1-5, where 1 is extremely negative and 5 is extremely positive? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

EMPLOYMENT HISTORY

What is your current employment status? (check all that apply) ☐ Full-time ☐ Part-time

☐ Self-employed ☐ Unemployed ☐ Student ☐ Seeking career change ☐ Retired ☐ Disabled

Who is your employer?_____

What is your occupation?_____

What is your title?_____

How long have you worked there? _____

On average, how many hours do you work per week?_____

Average annual salary: ☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000

☐ $40,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

Have you ever been terminated from employment? ☐ Yes ☐ No **If yes, describe:** _____

_____

In what other organizations(s) are you involved (e.g., volunteer work) **and how many hours do you average volunteering per week?** _____

_____

LEGAL OR SOCIAL AGENCY INVOLVEMENT

Have you ever been arrested? ☐ Yes ☐ No **If yes, when and why?** _____

_____

Do you have past/current legal issues? ☐ Yes ☐ No **If yes, describe:** _____

_____

Have you ever had any involvement with the Department of Children & Families or similar agency in another state? ☐ Yes ☐ No **If yes, describe:** _____

_____

Have you ever been involved in any kind of domestic violence? ☐ Yes ☐ No **If yes, describe:** _____

_____

MENTAL/EMOTIONAL HEALTH HISTORY

What are your current/recent symptoms? (check all that apply)

- ☒ Abuse (physical, sexual, emotional)
- ☐ Addictive behaviors
- ☐ Angry outbursts
- ☐ Anxiety/panic attacks
- ☐ Apathy/indifference
- ☐ Appetite changes/concerns
- ☐ Avoidance
- ☐ Body image concerns
- ☐ Communication difficulties
- ☐ Compulsive behaviors
- ☐ Concentration difficulties
- ☐ Cultural concerns
- ☐ Crying spells
- ☐ Daydreaming
- ☐ Decision-making challenges
- ☐ Disconnected from self/others
- ☐ Dizziness
- ☐ Down or depressed mood
- ☐ Eating-related concerns
- ☐ Excessive energy
- ☐ Family difficulties
- ☐ Fatigue/low energy
- ☐ Fear (increased/irrational)
- ☐ Flashbacks
- ☐ Grief
- ☐ Guilt
- ☐ Hallucinations (auditory, visual, tactile)
- ☐ Headaches/migraines
- ☐ Helplessness
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Intimacy difficulties
- ☐ Intrusive memories/ thoughts
- ☐ Irritability
- ☐ Libido changes
- ☐ Loneliness
- ☐ Loss of control (or feeling of loss of control)
- ☐ Loss of interest
- ☐ Mood changes
- ☐ Motivation difficulties
- ☐ Nervousness
- ☐ Nightmares
- ☐ Obsessive thoughts
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Relationship difficulties
- ☐ Religious/spiritual concerns
- ☐ Risky activity
- ☐ School/work problems
- ☐ Self-blame
- ☐ Self-control
- ☐ Self-esteem/self-confidence concerns
- ☐ Self-injurious behavior
- ☐ Sexual difficulties
- ☐ Sleep difficulties/changes
- ☐ Social challenges
- ☐ Stress
- ☐ Stomach problems
- ☐ Substance use/abuse
- ☐ Suspiciousness
- ☐ Tension
- ☐ Thoughts of death/dying
- ☐ Trust difficulties
- ☐ Other: _____

_____

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Rate your current level of distress (where 1 is very little distress, and 10 is extreme distress):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you <u>previously</u> attended counseling for mental health concerns? ☐ Yes ☐ No **If yes:**

When?	Treated where or by whom?	Reason	Diagnosis	Treatment Outcome

If yes, what was helpful to you during treatment? _____

_____

Are you <u>currently</u> attending counseling for mental health concerns? ☐ Yes ☐ No **If yes:**

When?	Treated where or by whom?	Reason	Diagnosis	Treatment Outcome

Are you currently taking prescribed medication for mental health concerns? ☐ Yes ☐ No

Have you ever taken medication for mental health concerns? ☐ Yes ☐ No

If yes, detail all <u>current and past</u> medications:

Dates	Medication	Dosage	Prescribed by whom?	Reason	Diagnosis	How helpful is it?

Have you ever experienced the following? (check all that apply)

☐ Abuse by an intimate partner
☐ Animal attack
☐ Childhood emotional abuse
☐ Childhood physical abuse
☐ Childhood sexual abuse
☐ Diagnosed with life-threatening illness
☐ Imprisonment or torture
☐ Kidnapped or taken hostage
☐ Military combat or war zone experiences
☐ Natural disaster (e.g., flood, earthquake)
☐ Near drowning
☐ Physical attack (e.g., mugged, beaten up, shot, threatened with a weapon)
☐ Serious accident, fire, or explosion

☐ Sexual violence (e.g., rape or attempted rape, sexual assault)
☐ Stalked
☐ Terrorist attack
☐ Other (specify):_____

Question	Yes or No?	How many times?	When was the last time?
Has someone had sexual contact with you without your consent (e.g., you were afraid to stop what was happening, passed out, drugged/drunk/incapacitated/asleep, threatened or physically forced)**? If yes, describe:** _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)**? If yes, describe:** _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Question	**Yes or No?**	**How many times?**	**When was the last time?**
Have you experienced a traumatic event that caused you to feel intense fear, helplessness, or horror? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you been hospitalized for mental health concerns? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you purposely injured yourself without suicidal intent (e.g., cutting, burning, hitting, etc.)? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you seriously considered attempting suicide? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you made a suicide attempt? If yes, describe:	☐ Yes	☐ Never	☐ Never

_____ _____ _____	☐ No	☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Has anyone close to you died by suicide? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you considered causing serious physical injury to another person? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Question	**Yes or No?**	**How many times?**	**When was the last time?**
Have you intentionally caused serious physical injury to another person? If yes, describe: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago

What <u>positive things</u> do you do that impact your emotional health (e.g., meditation, read, exercise, hobbies, etc.)**?** _____

_____

<u>SUBSTANCE USE HISTORY</u>

Is there family history of addictions in your family (immediate or extended)**?** ☐ Yes ☐ No **If yes, describe:**

Are you in <u>recovery</u> from any addictive behavior? ☐ Yes ☐ No **If yes, from what substances and what are you doing to maintain your recovery?**_____

_____

Do you smoke cigarettes? ☐ Yes ☐ No **When did you start?** _____ **How many per day?**_____

Do you drink caffeinated beverages? ☐ Yes ☐ No **What type and how many per day?** _____

_____

Have you ever taken prescription drugs that were not prescribed to you? ☐ Yes ☐ No

If yes, when, which drug(s), how much, and for what purpose? _____

_____

Have you ever taken more than the prescribed dosage of a prescription drug(s)? ☐ Yes ☐ No

If yes, when, which drug(s), how much, and for what purpose? _____

_____

Have you used the following in the past or present? (check all that apply)

	Present	Past
Acid/LSD/etc	☐	☐
Beer/wine/liquor	☐	☐
Benzos/Xanax/Valium	☐	☐
Cocaine/crack/etc	☐	☐
Ecstasy	☐	☐
Heroin/opium/etc	☐	☐
Inhalants/whipits	☐	☐
Marijuana/hash	☐	☐
Methadone	☐	☐

	Present	Past
Methamphetamine/Speed	☐	☐
Mushrooms/etc.	☐	☐
Pain Killers	☐	☐
Rx/OTC drugs	☐	☐
Stimulants (Pills)	☐	☐
Tobacco	☐	☐
Other (specify)	☐	☐

_____

If yes to any of the above, describe frequency and date ranges of use: _____

_____

Question	Yes or No?	How many times?	When was the last time?
Have you ever felt the need to reduce your alcohol or drug use?	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have others ever expressed concern about your alcohol or drug use?	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you ever been treated for drug/alcohol abuse? If yes, describe when, where, and why: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago
Have you ever been hospitalized due to use of drugs/alcohol? If yes, describe when, where, and why: _____ _____ _____	☐ Yes ☐ No	☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times	☐ Never ☐ Within the last 2 weeks ☐ Within the last month ☐ Within the last year ☐ Within the last 1-5 years ☐ More than 5 years ago

Describe any problems/consequences you have experienced as a result of your use: _____

_____

_____

Do you engage in any of the following behaviors in such a way that it may be a concern?

☐ Eating (over, under, restricting, binging/purging)
☐ Exercise
☐ Gambling
☐ Internet

_____

☐ Sexuality ☐ Other: _____

☐ Spending

SLEEP HYGIENE

What is your typical sleep experience? (check all that apply)

☐ Sleep through the night ☐ Sleep all the time

☐ Cannot sleep at all ☐ Sleeping more than usual

☐ Difficulty getting to sleep ☐ Wake up too early

☐ Do not feel rested after sleep ☐ Waking during the night

☐ Dreaming (good/bad) ☐ Other (specify):

☐ Nightmares _____

Typical bed time: _____ **Typical wake time:** _____

Average hours of sleep per night: _____

Describe the typical activities you do within two hours of bedtime: _____

_____

MEDICAL HISTORY

Describe any significant events about your birth (e.g., premature, illness, medical condition)**:**_____

_____

How would you rate your physical health? ☐ Very good ☐ Good ☐ Average ☐ Poor

☐ Declining ☐ Other (specify) _____

When was your last physical examination and what were the results?_____

_____

When was your last blood workup and what were the results? _____

_____

List any important present or past illnesses, conditions, injuries, or disabilities: _____

_____

_____

What medications are you currently taking for physical health? _____

_____

Who is your current primary care physician? _____

What prior surgeries have you had? _____

What allergies do you have?_____

Have you had recent weight changes? ☐ Lost (lbs.): _____ ☐ Gained (lbs): _____

Current appetite: ☐ Excessive ☐ Good ☐ Fair ☐ Poor

Past appetite: ☐ Excessive ☐ Good ☐ Fair ☐ Poor

Do you…

Skip meals? ☐ Frequently ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

If you skip meals, is it intentional? ☐ Yes ☐ No

Eat a lot? ☐ Frequently ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Feel out of control when eating? ☐ Frequently ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Vomit? ☐ Frequently ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Take diuretics/laxatives? ☐ Frequently ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

What is your exercise frequency? ☐ More than once a day ☐ Daily ☐ 4-5 times/week ☐ 2-3 times/week

☐ 1 time/week ☐ Every other week ☐ Monthly ☐ Rarely ☐ Never

Exercise type(s): _____

What positive things do you do that impact your physical health (e.g., exercise, eat well, take vitamins, etc.)**?** _

_____

DISABILITY HISTORY

Do you have a documented/diagnosed disability? ☐ Yes ☐ No

If yes, please indicate the category of disability (check all that apply):

☐ Attention Deficit/Hyperactivity Disorders
☐ Deaf or hard of hearing
☐ Learning disorders
☐ Mobility impairments
☐ Neurological disorders
☐ Physical/health related disorders
☐ Psychological disorder/condition
☐ Visual impairments
☐ Other (specify):_____

Are you registered with your school/place of employment for disability accommodations? ☐ Yes ☐ No

Are you registered with the government to receive disability benefits? ☐ Yes ☐ No

HOUSEHOLD HISTORY

With whom do you currently live? (check all that apply) ☐ Alone ☐ Spouse/partner/sig. other

☐ Roommate(s) ☐ Child(ren) ☐ Parent(s)/guardian(s) ☐ Sibling(s) ☐ Other (specify): _____

Describe your current living conditions (e.g., what type of housing, safety of housing, condition of dwelling)**:**__

_____

Describe your current financial condition (e.g., financial stress, access to resources): _____

_____

FAMILY OF ORIGIN HISTORY

Where did you grow up? _____

Who raised you? _____

Were you adopted? ☐ Yes ☐ No **If yes, at what age?** _____

Rate your childhood: ☐ Unhappy ☐ Average ☐ Happy ☐ Very happy

Describe any significant events that occurred in your childhood that you feel impacts your current situation: _____

_____

Answer this section describing your parents/guardians/people who raised you:

_____

Person & Age *or* age at death	Deceased (if yes, when?)	Occupation	Current relationship status:	Relationship length	Describe him/her
Father Age: _____	☐ Yes ☐ No		☐ Single ☐ Partnered ☐ Cohabitating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed	_____ year(s) _____ month(s)	
Mother Age: _____	☐ Yes ☐ No		☐ Single ☐ Partnered ☐ Cohabitating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed	_____ year(s) _____ month(s)	
Step-Father Age: _____	☐ Yes ☐ No		☐ Single ☐ Partnered ☐ Cohabitating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed	_____ year(s) _____ month(s)	
Step-Mother Age: _____	☐ Yes ☐ No		☐ Single ☐ Partnered ☐ Cohabitating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed	_____ year(s) _____ month(s)	
Other: _____ _____ Age: _____	☐ Yes ☐ No		☐ Single ☐ Partnered ☐ Cohabitating ☐ Engaged ☐ Separated ☐ Divorced ☐ Widowed	_____ year(s) _____ month(s)	

If your parents divorced, how old were you at the time?_____

Describe your relationship with your mother/mother figure:_____

_____

Describe your relationship with your father/father figure: _____

_____

List any sibling(s), their age(s), and describe your relationship(s) with them: _____

_____

_____

List any family member medical conditions and related treatment(s)/medication(s): _____

_____

List any family member mental/emotional conditions and related treatment(s)/medication(s):_____

_____

Have there been any recent significant deaths in your family or social circle? ☐ Yes ☐ No

If yes, describe: _____

RELATIONAL HISTORY

What is your current relationship status? ☐ Single ☐ Serious dating or committed relationship

☐ Engaged ☐ Civil union, domestic partnership, or equivalent ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Self-identify (specify): _____

Are you content with your current relationship status? If no, briefly describe why: _____

_____

Name of spouse/partner: _____

How would you describe your partner? _____

How long have you known your current partner? _____

Rate your current partnership/marriage: ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy

Is your partner supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ Partner unaware

If your relationship is a concern, is your partner/spouse willing to seek counseling?

☐ Yes ☐ No ☐ Unsure ☐ Spouse/partner in individual counseling ☐ We're in couple's counseling

Specify the length of partnership/marriage: _____

If you are divorced, specify date(s) of divorce:_____

Number of prior marriages for you: _____

Number of prior marriages for your partner/spouse: _____

If you are widowed, specify date(s) widowed: _____

Have you placed a child for adoption? ☐ Yes ☐ No **Have you had an abortion?** ☐ Yes ☐ No

Have you had a miscarriage? ☐ Yes ☐ No **Have you had a stillborn?** ☐ Yes ☐ No

List your child(ren) (including living, placed for adoption, miscarried, aborted, or deceased):

Name	**Sex/ Gender Identity**	**Age** (current, at adoption, or death) ***and*** **year of death**, if applicable	**Relationship to you**	**Living with you?**	**Describe him/her and your relationship**
			☐ Natural ☐ Adopted ☐ Step	☐ Yes ☐ No ☐ Part-time	
			☐ Natural ☐ Adopted ☐ Step	☐ Yes ☐ No ☐ Part-time	
			☐ Natural ☐ Adopted	☐ Yes ☐ No	

			☐ Step	☐ Part-time	
			☐ Natural ☐ Adopted ☐ Step	☐ Yes ☐ No ☐ Part-time	

Other children: _____

_____

SOCIAL SUPPORT

Please indicate how much you agree with the following statements:

"I receive the emotional help and support I need from my family."

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

"I receive the emotional help and support I need from my social network (e.g., friends & acquaintances)**."**

☐ Strongly disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly agree

How many supportive people (those on whom you can depend) do you currently have in your life?

☐ None (0) ☐ Few (1-3) ☐ Some (4-5) ☐ Many (6+)

ADDITIONAL INFORMATION

Is there anything else you'd like the counselor to know? _____

_____

_____

_____

_____

_____

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