Kairos Coaching & Counseling, LLC

CONFIDENTIAL INTAKE ASSESSMENT

The purpose of this assessment is to obtain a comprehensive understanding of your life experience and background. Completing these questions as fully and as accurately as you can will benefit you through the development of a treatment program suited to your specific needs. Please return this assessment at your first scheduled appointment.

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Name: _____

Address: _____

City: State: Zip: _____

Telephone numbers:
Home: _____Work:_____ Cell Phone: _____
Email address: _____
Preferred method of contact:_____

Gender: _____Age:_____ DOB: _____
Place of Birth:_____

Who referred you to us? _____

Who should we contact in an emergency?
Name: _____
Relationship: _____
Address: _____
Telephone: _____

SOCIO-ECONOMIC HISTORY (check all that apply)

Living situation:
[ ] housing adequate [ ] homeless [ ] housing overcrowded
[ ] dependent on others for housing [ ] housing dangerous/deteriorating
[ ] living companions dysfunctional

Who currently lives in your home? _____
_____

Social Support:
[ ] supportive network [ ] few friends [ ] no friends [ ] distant from family of origin
Who do you lean on for support?
_____

Education:
Highest level achieved: [ ]High School [ ]GED [ ]some college [ ]Bachelor [ ]Master [ ]Doctorate College Major or emphasis: _____
Employment:
[ ] employed and satisfied [ ] employed but dissatisfied [ ] unemployed
[ ] coworker conflicts [ ] supervisor conflicts [ ] unstable work history [ ] disabled
If employed, what is your occupation? _____

Financial situation:
[ ] no current financial problems [ ] large indebtedness [ ] poverty or below-poverty income [ ] relationship conflicts over finances [ ]impulsive spending

Legal history:
[ ]no legal problems [ ]currently on parole/probation
[ ]non substance-related arrest(s)
[ ]substance-related arrest(s)
[ ]jail/prison _____# of times _____ charges _____
total time served: _____ where? _____

Military history:
[ ]never in military [ ]active duty [ ]retired [ ]military spouse

Sexual history:
[ ]heterosexual [ ]homosexual [ ]bisexual

Significant relationship status (check one):
[ ]single(never married) [ ]divorced [ ]engaged [ ]remarried [ ]married
[ ]committed relationship [ ]separated [ ]widowed

Relationship history:
If engaged, married, separated, divorced or widowed, for how long?_____
Living together in a committed relationship? Yes No
How long have you been together? _____
Number of previous marriages for you:_____ For your spouse: _____
If married, spouse's name: ____ Age: ___ Occupation: _____
Is your spouse supportive of seeking counseling?
[ ]Yes [ ]No [ ]Unsure [ ]Spouse doesn't know
Children: [ ]none
Please list your children (including step, adopted, foster), their ages and with whom they live:
_____
_____
_____

SPIRITUAL/RELIGIOUS HISTORY

Do you regularly attend a church, synagogue, or other religious institution? If so, where? _____

Childhood religious affiliation, if different from above: _____

Describe the religious atmosphere you were raised in?

_____

_____

_____

How did you feel about your childhood religion?

_____

_____

What did your religious training teach you about life?

_____

_____

What is the role of religion/spirituality in your life?

_____

_____

Describe any spiritual experiences that have shaped your life:

_____

_____

CHIEF COMPLAINT (Check all that apply to you):

__Depression
__low energy/fatigue
__low self-esteem
__poor concentration
__hopelessness
__worthlessness
__sleeping problems
__overeating
__isolation/social w/draw
__anxiety/panic
__prescription abuse
__sexual abuse
__see things others don't
__sexual problems
__career/work problems
__Feeling that you are not real
__nightmares
__racing thoughts
__anger/frustration
__easily agitated/annoyed
__impulsive behavior
__excessive sleeping
__grief/loss
__apathy
__argues/blames others
__emotional abuse
__spousal abuse
__hearing voices
__marital problems
__fear of going crazy
__phobias
__unpleasant thoughts
__anorexia/bulimia
__excessive behaviors
__guilt
__loss of appetite
__mood swings
__stress
__alcohol/drug abuse
__physical abuse
__delusions
__confusion
__other relationship issues

PRESENTING PROBLEM/CHIEF COMPLAINT DESCRIPTION

State in your own words the nature of your main problem(s) and a brief history of your complaint(s) from onset to present:

_____

_____

_____
_____

On the scale below please use an "X" to indicate the severity of your problem(s):

```
I_____________I_____________I_____________I_____________I
I             I             I             I             I
```

Mildly Upsetting	Moderately Severe	Very Severe	Extremely Severe	Totally Incapacitating

Previous Treatment:

A. Were you ever hospitalized because of mental illness? [ ] Yes [ ]No
B. How many times have you been hospitalized?_____
C. When were you first diagnosed with a mental illness?_____
D. Have you previously consulted anyone about your present problem(s)? [ ]Yes [ ]No
E. Have you ever been in counseling before? If so, was this a positive experience for you? Please explain:

_____
_____

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, residential/in-patient care or hospitalizations, please list the names of the therapists, hospitals or programs below:

Therapist's Name/Hospital or Program Major Issue/Diagnosis Dates

_____
_____

Have you ever attempted suicide or homicide?

a. If yes, how many times _____

Are you currently feeling suicidal or homicidal?

a. If yes, do you have a plan? _____
b. If you have a plan, if so please describe your method _____
c. Do you have means to carry out your plan?_____
d. If yes, please explain _____

MEDICATION COMPLIANCE

A. If you are presently taking psychotropic medication(s) please list each one below, along with the dosage and frequency. Please also state who the prescribing physician is:

_____
_____
_____

B. Do you think your medication is helping? _____

C. Do you experience any side effects? If yes, describe symptom-
s_____

MEDICAL HISTORY: Please list any major conditions, illnesses, accidents, surgeries, treatments or hospitalizations and when they occurred?

_____
_____
_____

Are you currently receiving treatment? If yes, please describe:

_____
_____

Name any non-psychotropic prescriptions and over the counter medications and what you are taking them for

_____
_____
_____

When was your last physical exam? _____
Who is your Primary Care Physician? _____

FAMILY HISTORY:
Please list any biological family members who have Mental Health or Substance Abuse issues and give their diagnosis:

_____
_____
_____
_____

DESCRIBE YOUR CHILDHOOD FAMILY EXPERIENCE:
[ ] Outstanding [ ]Normal [ ]Chaotic
[ ] WItnessed physical/verbal/sexual abuse toward others.
[ ] Experienced physical/verbal/sexual abuse from others.

1. What traumas have you experienced? (ie. abuse, abortion, divorce, etc.)
   _____
   _____
2. Have any of your family members or friends ever attempted or committed suicide? If yes, please describe:
   _____

SUBSTANCE ABUSE HISTORY
Family alcohol/drug abuse history: [ ]father [ ]mother [ ]grandparents [ ]sibling(s)
[ ]uncles/aunts [ ]spouse/significant other [ ]children [ ]other_____

Your substance use status: [ ]no history of abuse [ ]active abuse [ ]no active use/dependence in 1-11mos. [ ]abuse/dependence in 1-11 mos.
[ ]no active abuse/dependence in over 12 months [ ]abuse/dependence in over 12 months.

Substances used: Check all that apply.

	Age of 1st use	Last use	Current Use Yes/No	Frequency	Amount
__alcohol					
__amphetamines/ speed					
__barbiturates					
__caffeine					
__cocaine					
__crack					
__hallucinogens					
__inhalants					
__marijuana					
__nicotine					
__PCP					
__prescription					

Consequences of substance abuse (check all that apply):

[ ]hangovers	[ ]withdrawal symptoms	[ ]sleep disturbances	[ ]binges
[ ]seizures	[ ]medical conditions	[ ]assaults	[ ]job loss
[ ]blackouts	[ ]tolerance changes	[ ]suicidal impulse	[ ]arrests
[ ]overdose	[ ]relationship conflicts	[ ] loss of control in amount used	

Treatment history:
[ ] outpatient (age) _____ where? _____
[ ] inpatient (age) _____ where? _____
[ ] 12-step program [ ] stopped on own