EVE
Counseling & Coaching, LLC
Encourage, enVision, Empower

INTAKE

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial ___

Age _____ Date of Birth _____ Social Security # _____

Address: _____

Eve Counseling & Coaching, LLC may send information to my home address: Yes _____ No _____

Telephone/electronic media Contacts **(provide the following telephone contact information and email address as indicated below and check Yes or No as follows):**

Home: _____You may contact this number and leave a voice mail Yes ____ No _____

Work: _____You may contact this number and leave a voice mail Yes ____ No _____

Cell: _____You may contact this number and leave a voice mail Yes ____ No _____

Email Address: _____You may email me Yes ____ No _____

Text Messages: You may text me Yes ____ No _____

Emergency contact person (name): _____ Relationship to you: _____

Emergency Contact Phone Number: _____Okay to leave a voice mail: Yes ___ No ___

Ethnicity: Individuals are asked to first designate ethnicity as (select one):

- Hispanic or Latino ☐
- Not Hispanic or Latino ☐

Second, individuals are asked to indicate one or more races that apply among the following:

- American Indian or Alaskan Native ☐
- Asian ☐
- Black or African American ☐
- Native Hawaiian or Other Pacific Islander ☐
- Caucasian/White ☐
- Other (please indicate) _____

Marital Status

☐ Married, how long _____
☐ Currently partnered
☐ Separated from live-in partner
☐ Divorced, how long _____
☐ Widowed, how long _____
☐ Multiple marriages, how many _____
☐ Never married
☐ Separated, how long _____

Spouse/Significant others Name: _____ Age: _____

What is your sexual orientation?
☐ Heterosexual ☐ Homosexual/Lesbian/Gay ☐ Bi-sexual ☐ Transsexual

Do you have children? If yes, list their names and ages:
_____

What is the highest degree or level of education you have completed?
☐ No schooling completed
☐ Nursery school to 8th grade
☐ 9th, 10th or 11th grade
☐ 12th grade, no diploma
☐ High school graduate - high school diploma or the equivalent (for example: GED)
☐ Some college
☐ Associate degree (for example: AA, AS)
☐ Bachelor's degree (for example: BA, AB, BS)
☐ Master's degree (for example: MA, MS, MSW, MBA)

Household Income--What is your total household income?
☐ Less than $10,000
☐ $10,000 to $19,999
☐ $20,000 to $29,999
☐ $30,000 to $39,999
☐ $40,000 to $49,999
☐ $50,000 to $59,999
☐ $60,000 to $69,999
☐ $70,000 to $79,999
☐ $80,000 to $89,999
☐ $90,000 to $99,999
☐ $100,000 to $149,999
☐ $150,000 or more

What are some of your hobbies/interests? _____

How did you find out about Eve Counseling & Coaching, LLC? _____

What is the major reason you are seeking counseling? _____

_____

_____

When did the problem begin? _____

What are your goals for counseling? _____

_____

Current Symptoms Checklist: (check all that apply)

( ) Depressed Mood
( ) Unable to enjoy activities
( ) Sleep disturbance
( ) Loss of interest in things
( ) Concentration/forgetful
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased Libido
( ) Racing Thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Increased libido
( ) change in sleep pattern
( ) excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive Worry
( ) Anxiety Attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Hopeless
( ) Take sleeping pills

Suicide Risk Assessment

1. Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
2. If YES, please answer the following questions; if NO, please skip to question No. 15
3. Do you **CURRENTLY** feel that you don't want to live? ( ) Yes ( ) No
4. How often do you have these thoughts? _____
5. When was the last time you had thoughts of dying? _____
6. Has anything happened recently to make you feel this way? _____
   _____
7. On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill yourself? ___
8. Would anything make it better? _____
9. Have you thought about how you would kill yourself? _____
10. Is the method you would use readily available? _____
11. Have you planned a time for this? _____
12. Is there anything that would stop you from killing yourself? _____
    _____
13. Do you feel hopeless and/or worthless? ( ) Yes ( ) No
14. Have you ever tried to kill or harm yourself before? ( ) Yes ( ) No
15. Do you have access to guns? ( ) Yes ( ) No

List all current prescription medications and how often you take them:

Medication Name Daily Dosage Estimated Start Date

_____

_____

_____

Prescribing Physician: _____

Current over-the-counter medications and supplements: _____

_____

Current medical problems: _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

Did your parents' divorce? ( ) Yes ( ) No If yes, how old were you? _____

If your parents divorced, whom did you live with? _____

Briefly describe your relationship with your father _____

Briefly describe your relationship with your mother _____

Has anyone in your immediate family died? ( ) Yes ( ) No
If yes, list who died, when, and the cause of death: _____

History of Abuse: *check those that apply*

☐ Sexual Abuse ☐ Physical Abuse ☐ Verbal/Emotional Abuse ☐ Drug/Alcohol Abuse

Substance Use:
Have you ever been treated for alcohol or drug abuse? ( ) Yes ( ) No
If yes, for which substances? _____
How many days per week do you drink any alcohol or other substances? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you gone to AA, NA, or other 12-Step Program/Self-help group? ( ) Yes ( ) No

Current Living Situation:

List everyone who currently lives with you: _____

_____

_____

Past Mental Health/Counseling and/or Substance Abuse Treatment History
Include inpatient and/or outpatient counseling, psychiatric hospitalizations or other treatment

Dates of Treatment **Facility** **Name of Treatment Provider (counselor)**

_____

_____

_____

Has any family member been treated for a mental health or psychiatric illness? ( ) Yes ( ) No
If yes, who and how did they respond to treatment? _____

_____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in your present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch/when? _____
Honorable discharge? ( ) Yes ( ) No Other type of discharge: _____

Legal History:
Have you ever been arrested? ( ) Yes ( ) No If yes, when _____
Have you ever been convicted of a crime? ( ) Yes ( ) No
If you have been convicted what was the nature of the crime: _____
Do you have any pending legal problems? ( ) Yes ( ) No
Will you require documentation of your counseling? ( ) Yes ( ) No

Spiritual/Religious Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is your level of involvement? _____
Do you find your spirituality more or less helpful during times of illness and stress?
( ) more helpful ( ) less helpful

Exercise Level:
Do you exercise regularly: ( ) Yes ( ) No

Client Signature: _____ **Date:** _____