Paulette Sears Counseling, LLC
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Intake and Assessment

Please complete the following to the best of your ability.

Name: _____________________________________ Age: _____ Birthdate: ____________________

Presenting Problem

State in your own words the nature of the problem you are seeking help for: ____________________
____
____

When did the problem begin? (Approximate dates and circumstances): ________________________
____
____

What do you hope to accomplish through the counseling process?
____
____

Lifestyle Behaviors – Briefly describe:

Eating habits (i.e. frequently overeat, erratic, on a diet…) ____________________________________
____
Sleep/Rest Patterns (how much, restful, toss & turn) ______________________________________
____
Physical Exercise (how much, what kind)____
Use of Alcohol (frequency, how much, what kind) ____
____
Use of Other Drugs (frequency, how much, what kind) _____________________________________
____
Caffeine Intake (how much, in what) ____
____
Smoking (how much) ____

Current Concerns. Please circle any area where you think you may have a PROBLEM:

Anger/Temper	Anxiety/Nervousness	Stress/Burnout	Parenting Skills	Gambling Problem
Fears/Phobias	Behavior Problems	Work/Job/Career	Self-Concept	Recurring Nightmares
Indecision	Relationships	Depression	School Problems	Hopelessness
Irritability	Marital Problems	Suicidal Thoughts	Weight Loss/Gain	Finances/Money
Mood Swings	Sexual Problems	Menopause	Menstrual Problems	Self-Injury
Memory	Concentration	Hyperactivity	Alcohol/Drugs	Guilt

Other:____

Personal History

Name ____ **Age** _________ **Birthdate** __________________
Ethnicity ______________________________________

Marital Status
Single ____ Engaged ____ *How long*? ______ Married ____ *How long?* ________
Widowed ____ *Date* ____________ Divorced ____ *How long?*________

Children (List Names and ages)
____
____

Parents
Mother ________________________________ Age _______ Occupation_________________________
Deceased_____Age of death___________ Cause of death_______________________________

Father __________________________________ Age _______Occupation_________________________
Deceased_____Age of death___________ Cause of death_______________________________

Brothers and Sisters (List name(s) from oldest to youngest)
____
____
____
Who lives in your home? ____

Work
What is your present occupation or job title? ____
How long have you been employed with your present employer? ____________________________
Do you like your job? ____

Recreation & Leisure
What are your personal hobbies and/or interests? ____
____
How often do you involve yourself in your hobbies and other interests? ________________________
How often do you vacation? ____

Education
Highest grade completed _________________ Degree(s) completed _________________________
Did you have academic, behavioral, or social difficulties in school? ____________ Explain: __________
____
____
____
Strengths in school: ____

PHYSICAL HEALTH AND SYMPTOMS

Do you have any concerns about your physical health? Please Explain:
____
____
____

Are you currently under the care of a physician for treatment of a physical or emotional condition? ____
If yes, please list physician's name, reason for treatment, and date last seen _______________________
____

Current Physician ______________________________ Last Examination and Results:_____________
____

Please check any of the following that apply to you or a family member (currently or in the past):

	You	Others		You	Others
Thyroid Disease	___	_____	Infectious Disease	___	_____
Kidney Disease	___	_____	Diabetes	___	_____
Asthma	___	_____	Hypoglycemia	___	_____
Allergies	___	_____	Cancer	___	_____
High Blood Pressure	___	_____	Pulmonary Disease	___	_____
Neurological Disease	___	_____	Glaucoma	___	_____
Prostate Problems	___	_____	Gastrointestinal	___	_____
Heart Disease	___	_____	Epilepsy	___	_____
Premenstrual Syndrome (PMS)	___	_____	Sleep Disorder	___	_____
Abortion/Miscarriage	___	_____	Alcohol/Drug Problem	___	_____

Other: ____

Please check any of the following that apply to you:

	Never	Occasionally	Often	Very Often
Marijuana	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Narcotics	_____	_____	_____	_____
Painkillers	_____	_____	_____	_____
(Aspirin, Tylenol, etc)				
Cocaine	_____	_____	_____	_____
Speed	_____	_____	_____	_____
Gambling	_____	_____	_____	_____
Overeating	_____	_____	_____	_____
Tension	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Hyperventilation	_____	_____	_____	_____
Restless Sleep	_____	_____	_____	_____

MENTAL HEALTH

Have you ever been in counseling or received any form of professional help for your problems: _______

With Whom? When? ____

____

Was previous counseling or treatment helpful? (Explain) ___________________________________

____

Any history of psychiatric hospitalizations (dates & reasons) ________________________________

____

Any history of traumatic experiences of any nature? _______________________________________

____

Please check any of the following that often apply to you:

Anger ____	Tired ____	Peaceful ____	Annoyed ____	Guilty ____	Bored ____
Sad ____	Happy ____	Restless ____	Depressed ____	Hopeless ____	Tense ____
Anxious ____	Hopeful ____	Lonely ____	Energetic ____	Regretful ____	Content ____
Fearful ____	Helpless ____	Excited ____	Envious ____	Relaxed ____	Joyful ____
Optimistic____	Frustrated ____	Pessimistic____			

List three things you worry about the most:

____

____

____

When do you feel the most calmed and relaxed? ____

____

How would you like to feel? ____

What do you imagine your life looking like when the problem that brought you here is taken care of?

____

____

Marriage/Intimate Relationships

How long have you been married? ______(or) in a present relationship? ______ Partner's age? _______

Describe your partner's health: ____

Describe your partner's hobbies: ____

What do you like most about your partner? ____

What do you like least about your partner? ____

Describe any problems you see currently affecting your relationship: _________________________

____

____

To what extent can you depend on your partner for support (emotional and/or financial)? ___________

____

____

List previous relationships/marriages and the reason for their ending: ________________________

____

____

Signature: ____ Date: ___________________________