ELIZABETH DUNCKEL, MA, MFT
Licensed Marriage and Family Therapist #52727
EPICENTER COUNSELING
(650) 722-4334
1313 Laurel St. #214, San Carlos, CA 94070
Elizabeth@EpicenterCounseling.com
www.EpicenterCounseling.com

COUNSELING INTAKE FORM

Please complete the information requested based on the person who will be receiving counseling:

Counseling Intake Date: ________________________ REFERRAL SOURCE: __________________

The ***client*** is a(n): ☐ **Adult** ☐ **Couple** ☐ **Family** ☐ **Child** under age 18 or ☐ **Dependant Adult**

Name: ____

Street Address:____Apt_____________

City:_______________________________State:__________________Zip Code_____________

Gender: M F Age: __________ Date of Birth: _______/______/_______

Social Security Number: ______-_____-_______

Highest Grade/Degree(s) Completed: ____

Currently a Student: ☐ Yes ☐ No Where: ____

Occupation: ____

Place of Employment: ____

Insurance Program: ____

CONTACT DATA: How do you prefer I contact you ? ___________________________

Cell Phone: ( ) _______________________ (Secure Voicemail: ☐ Yes ☐ No)
Home Phone: ( ) _______________________ (Secure Voicemail: ☐ Yes ☐ No)
Office Phone: ( ) _______________________ (Secure Voicemail: ☐ Yes ☐ No)

(Note: A ***'secure' voicemail*** *means a safe and private voice mailbox approved by you where you can receive messages from your therapist).*

Email Address: ____

Is basic contact from the therapist to you by **email** approved by you? ☐ Yes ☐ No
Do you understand that **no therapy or therapy questions will be done by email** in respect of privacy and confidentiality? ☐ Yes ☐ No

IN CASE OF EMERGENCY I GIVE PERMISSION FOR MY THERAPIST TO CONTACT:

1) Name ____
Relationship to Client _______________________________Phone # (   ) __________________

2) Name ____
Relationship to Client _______________________________Phone # (   ) __________________

HEALTH HISTORY

Do you have a history of a ***medical condition or diagnosis***? ☐ Yes ☐ No
(Please describe: ____)
Do you consider yourself to be ***'healthy***?**'** ☐ Yes ☐ No
Are you currently taking any ***prescribed*** medications? ☐ Yes ☐ No
Are you currently taking any ***over-the-counter*** medications? ☐ Yes ☐ No
Do you recreationally use ***any substances*** not prescribed? ☐ Yes ☐ No
Have you ever thought of seeking or have gotten ***"recovery"*** from substance use? ☐ Yes ☐ No

If yes, to any of the above, please record below (including alcohol):

Substance: Amount/frequency: Reason/Need: Date of Last Use:

1)____

2)____

3)____

4)____

MENTAL HEALTH HISTORY:

Have you participated in therapy in the past? ☐ Yes ☐ No
(Check all types that apply: ☐ Individual ☐ Grooup ☐ Family ☐ Other __________________)

If yes, were you satisfied with the process and outcome? ☐ Yes ☐ No
If no, please share a bit as to why it was not satisfying.

____
____
____
____
____
____
____
____

Are you currently participating in therapy elsewhere? ☐ Yes ☐ No

If yes, please provide the therapist's name and phone number:

____

____

Are you under the care of a psychiatrist? ☐ Yes ☐ No

If yes, please provide the psychiatrist's name and phone number:

____

____

Are you currently taking any medications indicated to help with a mental or emotional health concern? ☐ Yes ☐ No

If yes, please provide a list of the name(s) of the medication and a brief explanation of why they have been prescribed to you:

____

____

____

____

____

____

____

____

Please briefly describe what brings you to seek therapy:

____

____

____

____

____

____

____

____

The following list explains some of the most common concerns addressed in psychotherapy. Please read this list and follow the directions below.

** STEP 1: Check the concerns you would like to explore with your therapist:*

** STEP 2: For checked items only, circle the degree to which the concern is currently problematic for you:*

Concern	Mild	Moderate	Serious	Severe
☐ 1. **Relationship difficulties**: breakup/loss of relationship; problems with romantic partner, friends or roommates	1	2	3	4
☐ 2. **Family problems**: divorce, separation, abuse; conflicts over money, roles, relationships or responsibilities	1	2	3	4
☐ 3. **Depression/moods**: depressed mood, loss of interest or pleasure, hopelessness; alternating periods of elevated and depressed mood	1	2	3	4
☐ 4. **Suicidal thoughts or concerns**: problems related to thoughts of suicide	1	2	3	4
☐ 5. **Anxiety**: excessive or uncontrolled worry, nervousness, chronic fears, performance anxiety, panic attacks, social anxiety, obsessive thoughts, checking behaviors	1	2	3	4
☐ 6. **Stress or psychosomatic symptoms**: overwhelmed by circumstances, problems with headaches, stomach pains, or sleep disturbances, etc.	1	2	3	4
☐ 7. **Anger management**: concerns about managing anger, hostility, or frustration	1	2	3	4
☐ 8. **Academic difficulties**: academic performance problems, missing classes	1	2	3	4
☐ 9. **College adjustment**: problems adjusting to campus life, relationship between academics and future goals	1	2	3	4
☐ 10. **Cultural adjustment**: difficulties adjusting or readjusting to North American social customs and mores	1	2	3	4
☐ 11. **Racial harassment**: targeted by words or behaviors that interfere with full participation in community life	1	2	3	4
☐ 12. **Self-esteem**: concern about self-image, shyness	1	2	3	4
☐ 13. **Death or loss**: grief related to loss of a valued other	1	2	3	4
☐ 14. **Existential/spiritual concerns**: search for meaning in life, concern about the role of religion in one's life	1	2	3	4
☐ 15. **Eating concerns and body image**: purging, restricting, compulsive overeating, unhealthy dieting, excessive exercise, poor or inaccurate body image	1	2	3	4
☐ 16. **Alcohol and/or chemical use**: concerns about abuse or developing dependency on alcohol or other drugs	1	2	3	4

☐ 17. **Self-inflicted harm**: concerns about physical self-harm, i.e., cutting, burning, etc.	1	2	3	4
☐ 18. **Medication**: concerns or questions about the appropriateness of medications	1	2	3	4
☐ 19. **Sexual abuse or harassment**: rape, incest, harassment, being the subject of obsessive pursuit by another	1	2	3	4
☐ 20. **Sexual health**: concerns related to sexual behavior	1	2	3	4
☐ 21. **Sexual identity**: concerns or questions around sexual orientation	1	2	3	4
☐ 22. **Conduct violation**: referred for violation of community conduct standards	1	2	3	4
☐ 23. **Other**: ____________________________________ ____	1	2	3	4

What do you hope to gain from counseling services?

____
____
____
____
____
____
____
____

What do you feel are your strengths?

____
____
____
____
____
____
____
____

Do you have any specific goals with regard to your treatment? ☐ Yes ☐ No

____
____
____
____
____

____
____
____

Do you have any particular concerns/fears with regard to treatment? ☐ Yes ☐ No

____
____
____
____
____
____
____
____

What do you like to do for fun? Include some of your skills and interests:

____
____
____
____
____
____
____

FAMILY AND LIVING SITUATION:

________________________***FOR MINOR CHILDREN AS CLIENTS***__________________________

1) **The client is a child who lives with:**
   - ☐ an intact family in one household, or
   - ☐ lives with mother, or
   - ☐ lives with father, or
   - ☐ other ______________________________________

2) Divorced parents must provide the legal custody agreement paperwork: ☐ ***Included***

3) The Custody Arrangement is:

ALL CLIENTS

Please list all the persons living in your home, their relationship to you and their age:

____
____
____
____
____
____

Please list family members involved in substance or alcohol use that concerns you in any way and explain:

____
____
____
____
____
____

Is there any family dynamic you think your therapist should know about?

____
____
____
____
____
____

Are your parents living? ***Mother***: ☐ Yes ☐ No ***Father***: ☐ Yes ☐ No

If not, when did each die and from what:

____
____

Are your parents married to each other? ☐ Yes ☐ No

Briefly describe their relationship:

____
____

Briefly, tell about your parents, their professions, and *anything* you consider significant:

____
____
____
____
____
____

ADDITIONAL INFORMATION:

Is there *anything* this form did not ask, but you feel is important information regarding your counseling/treatment or situation that your counselor should know? (Feel free to use the back of this form if more space is needed): ☐ **Yes** ☐ **No**

____
____
____
____
____
____
____
____

This form is completed by (print your name): ____

You are the ☐ Adult Client (self) ☐ Mother ☐ Father ☐ Youth (under age 18 yrs)
☐ Another Legally Responsible Adult (relationship to client): _______________________

I confirm by my signature on this form that all the information provided above is, to the best of my knowledge, accurate and complete.

Date: ___________________ Signature: ______________________________

Therapy is meant to Explore
And to Heal
I am Honored that you have Chosen Me
To Assist you on this Journey

Sincerely,
Elizabeth Dunckel
at Epicenter Counseling