IMARA COUNSELING SERVICES

INFORMATION FACE SHEET/INTAKE

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	
# of Dependents:	Gender: M ____ F ____ Other:_____
Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Home Phone:	Is it ok to leave a message for you at this number? Y / N
Mailing Address:	
E-mail Address:	
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
How long on this Job:	Do you enjoy your job?
Education Level:	Special Trainings:
Hobbies:	Military Background: Yes ____ No _____
Talents:	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Physical Health Data:

Describe your Physical Health: Excellent: ____Good: ____Average____Poor_____Weight:_____Height:____

Are you now under a doctor's care? _____If yes, name of doctor_____

Reason for doctor's care_____

Hospitalizations and Reasons:_____

_____

Have you ever been hospitalized for a mental illness?____ Describe_____

Do you have any previous mental health diagnosis?_____

Have you ever suffered from an eating disorder, such as bulimia, anorexia or obesity?_____

Recent major illnesses or surgeries_____

Do you have any current concerns about your physical health? Please specify: _____

_____

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):_____
_____

Do you get regular exercise? If so, what type and how often?_____

Check any of the following that apply to you:

	Never	Rarely	Frequently	# of times		Never	Rarely	Frequently	# of times
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Other:_____

Physical – check any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don’t like being touched

Family Data:

1. Birthplace: _____

FATHER: age now if living: _____Age at Death_____Cause: _____Your age then:_____

MOTHER: age now if living _____Age at Death _____Cause: _____Your age then:_____

2. Are your parents still together?____ Divorced?_____If divorced, when did the divorced occur?_____

Who do you consider to be your predominate care-giver growing

up?_____

3. Your Marital Status_____#of marriages _____Spouse's Name_____

4. Living with a partner _____How long _____Partner's Name_____

5. Do you have children?_____ How many?_____

6. SIBLINGS: When growing up how many brothers and sisters did you have?_____

7. Did you have/still have a close relationship with them?_____

8. Is there a history of alcoholism/drug addiction in the family?_____ if yes, which side?_____

9. Is there a family history of sexual Addictions or abuse?_____ if yes, which side?_____

10. Have you ever experienced any abuse or neglect in your lifetime?_____if yes, was it emotional, physical, sexual?

LEGAL DATA

Have you ever been incarcerated (Jail or Prison)? Yes _____No_ _____Dates_____

Reason_____Where_____

Have you ever had a DWI (Driving While Intoxicated)? Yes _____No_____How Many:_____

Are you currently on Probation/Diversion/Parole? Yes _____No_____Explain_____

Religious Data:

Current Religious Preference:_____

In Childhood:_____

List 3 Strengths you believe you have:

1._____

2._____

3._____

List 3 Weaknesses you believe you have:

1._____

2._____

3._____

List 3 Support Systems you have in your life right now:

1._____

2._____

3._____

Behavior – check any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Do you have any former diagnosis of a behavioral disorder?_____

On a scale 1-10, how bothered are you by the behaviors you circled?_____

Do you feel depressed, anxious, or have any other emotional disturbances on a daily or weekly basis?
Y?___N?____
If so, please explain,_____

Have you ever tried to harm yourself or others?_____

Have you ever had suicidal thoughts, plans, or ideations? _____
if so, have you ever acted on these thoughts? Yes_____ No _____ (If yes please explain)
_____

_____

Are there any specific behaviors, actions, habits that you would like to change? _____

Feelings – check any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Alcohol and drug History:

Have you ever been in treatment for Chemical Dependency/Addiction? Yes_____No_____
If Yes, Where:_____

Have you ever felt you should cut down on your drinking and/or drug use? Yes_____ No_____
Have people annoyed you by criticizing your drinking and/or drug use? Yes_____ No_____
Have you ever felt bad or guilty about your drinking and/or drug use? Yes_____ No_____
Have you ever had any D.T.'s? (Delirium tremens) Yes_____ No_____
Have you experienced any blackouts from drugs or alcohol? Yes_____ No_____
Have you ever injected drugs? Yes_____ No_____

Please list any substances you have used, the age you started using them, and the frequency of usage:_____

_____

_____

_____

Is there anything else you would like for me to know about you?_____
_____