# IMARA COUNSELING SERVICES

## Information Face Sheet/Intake

Note: The information on this form will be kept confidential

**Demographic Information:**

| | |
|---|---|
| Name: | Date: |
| Date of Birth: | Relationship Status: ☐ Married ☐ Single |
| Age: | Sexual Orientation: |
| Number of Dependents: | Gender Identity: |
| Mobile Phone: | Is it ok to leave a message for you at this number? ☐ Yes ☐ No |
| Home Phone: | Is it ok to leave a message for you at this number? ☐ Yes ☐ No |
| 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? ☐ Yes ☐ No |
| Education Level: | Special Trainings: |
| Hobbies: | Do you have military Background? ☐ Yes ☐ No |
| Talents: | |
| Emergency Contact Name: | |
| ER Contact Relationship: | Emergency Contact Phone: |
| How were you referred to ICS? | If online, which website? |

**Physical Health Data:**

Describe your Physical Health: ☐ Excellent ☐ Good ☐ Average ☐ Poor Weight ____________________ Height: ____________________

Are you currently under a doctor's care? ☐ Yes ☐ No If yes, name of doctor________________________________________________

Reason for doctor's care ____________________________________________________________

Hospitalizations and Reasons: ____________________________________________________________

____________________________________________________________

Have you ever been hospitalized for a mental illness? ☐ Yes ☐ No If yes, when? ________________________________________

Do you have any previous mental health diagnosis? ☐ Yes ☐ No If yes, what? ________________________________________

Have you ever suffered from an eating disorder, such as bulimia, anorexia or obesity? ☐ Yes ☐ No If yes, please specify ____________________

Recent major illnesses or surgeries ____________________________________________________________

Do you have any current concerns about your physical health? ☐ Yes ☐ No If yes, specify: ________________________________________

____________________________________________________________

Please list and proscribed medicines you are currently taking, or have taken during the past 6 months):

______________________________________________________________________________

______________________________________________________________________________

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* | | | | |

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? ☐ Yes ☐ No If divorced, when did the divorced occur? ___________________________

Whom do you consider to be your predominate care-giver growing up? ___________________________

3. Your Marital Status __________ If married, #of marriages __________ Spouse's Name ___________________________

4. Do you live with a partner? ☐ Yes ☐ No How long? __________ Partner's Name ___________________________

5. Do you have children? ☐ Yes ☐ No 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? ☐ Yes ☐ No

8. Is there a history of alcoholism/drug addiction in the family? ☐ Yes ☐ No if yes, which side? ___________________________

9. Is there a family history of sexual addictions or abuse? ☐ Yes ☐ No if yes, which side? ___________________________

10. Have you ever experienced any abuse or neglect in your lifetime? ☐ Yes ☐ No if yes, please check a box ☐ emotional ☐ physical ☐ sexual

**LEGAL DATA**

Have you ever been incarcerated (Jail or Prison)? ☐ Yes ☐ No Dates: ___________________________

Reason ___________________________ Where ___________________________

Have you ever had a DUI (Driving Under Intoxication)? ☐ Yes ☐ No How Many: ___________________________

Are you currently on Probation/Diversion/Parole? ☐ Yes ☐ No If yes, explain ___________________________

**Religious Data:**

Current Religious Preference: ___________________________

In Childhood: ___________________________

**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? ☐ Yes ☐ No If yes, what? ___________________________

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? ☐ Yes ☐ No If so, please explain:

___________________________

Have you ever tried to harm yourself or others? ☐ Yes ☐ No

Have you ever had suicidal thoughts, plans? ☐ Yes ☐ No 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? ☐ Yes ☐ No If yes, please explain ____________________________

______________________________________________________________________

**Feelings** – check any of the following feelings that may apply to how you are currently feeing or have felt over the last 60 days:

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ 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:

______________________________________________________________________

______________________________________________________________________

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 currently have in your life that you can depend on:

1.____________________________________________________________

2.____________________________________________________________

3.____________________________________________________________

Is there anything else you would like for me to know about you? ☐ Yes ☐ No If yes, please explain ________________________________________

______________________________________________________________________

______________________________________________________________________