Dr. Polacheck Therapeutic Services

INDIVIDUAL INTAKE FORM

Welcome to Dr. Polacheck therapeutic Services. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me better understand your situation as well as potential solutions in helping you get your life back on track. Please note, this information is confidential, for our use only, and will not be released to anyone without your written permission.

Personal Information
Client Name: Date of Birth:
Age: _____
Street Address:

City/State: Zip Code:

Sex: Female Male Transgender M to F or Transgender F to M

Religious Affiliation (if any):
Home Phone

Work Phone

Cell Phone

Email Address:

In an emergency, who do we call?
Contact Name: Contact Phone:
Employer:
Length of Employment:
Occupation:
Highest Level of Education Completed:

Social / Family Information
Which best describes you?
Choose all that apply: Never Married Married Separated Divorced Widowed Engaged Living Together Same-Sex Partners

If you are currently in a romantic relationship, for how long? .

On a scale of 1 to 10 (with 10 being best), how would you rate your satisfaction with your current relationship? .

Do you have children?
If so, please provide names and ages:

If you have listed children, with whom do they live?

Do you have any pets in the home? If so, what type?

List any other individuals living in your home (other than you and any children listed above):

Medical and Mental Health History / Information
Are you currently being treated by a physician for any medical conditions? If so, please describe:

Are you currently taking prescription, over-the-counter or herbal medication? No Yes; Medication name/dose:

Have you ever seen a Psychiatrist or other mental health provider? No Yes; If yes, when?

What was the focus of treatment?

Was it helpful? Yes No

Counseling Concerns
What are the issues for which you are currently seeking assistance? Please be as specific as possible.
1.

2.

3.

4.

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/ friends)? Has anything been helpful?

What are some of your coping strategies?

What do you consider to be your strengths?

Counseling Goals

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.
1.

2.

3.

Risk Assessment
Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis:

Please list family, friends, support groups and community groups which are helpful to you:

List any personal history of emotional, physical, and/or sexual abuse:

Has a family member or close friend ever committed suicide? No Yes, (who)

Have you been having any thoughts of harming yourself or others?
Yes No Self Other(s)

Are there any guns or weapons in your house (specify whose & what type)
Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state who and under what circumstances:

Alcohol / Substance Use Survey
How often do you have a drink containing alcohol? How many?

Do you use marijuana or other “street drugs”? (Remember, this information is confidential)

No Yes; what type/quantity/frequency of use:

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here