Doreen A. Zaborac & Associates, Inc.

Zaborac Counseling Group

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Intake Form (Adults)

Client Name:________________________________ D.O.B.__________ Age: ________

What made you decide to seek counseling:

____

____

Mental Health History:

Have you previously received mental health services (counselors, psychiatrist, etc.)? ▢ YES ▢ NO

If yes, who did you see and for how long?____

____

Have you been inpatient for mental health difficulties? ▢ Yes ▢ No

If YES, where, when, why, and length of hospitalization:____

____

Are you currently taking medication for a mental health condition? ▢ Yes ▢ No

Previous Medications (Name, Reason, Dosage): ____

____

____

Current Medications (Name, Reason, Dosage): ____

____

____

	Poor	Fair	Good	Excellent
How would you rate your current physical health?	▢	▢	▢	▢

Describe any physical or medical issues: ____

____

	Poor	Fair	Good	Excellent
How would you rate your current sleeping habits?	▢	▢	▢	▢

Describe any sleeping issues: ____

	Poor	Fair	Good	Excellent
How would you rate your current eating habits?	▢	▢	▢	▢

Describe any eating/appetite issues:____

	Poor	Fair	Good	Excellent
How would you rate your mental health?	▢	▢	▢	▢

Patient Name: ____

Please indicate your symptoms by checking the boxes that apply in the last six months: ▢ Low Self-Esteem

▢ Sadness/Depression ▢ Excessive Worry ▢ Tearfulness ▢ Lack of Interest/Motivation ▢ Panic Attack

▢ Difficulty Sleeping ▢ Too Much Sleep ▢ Anger/Irritability ▢ Lack of Focus ▢ Self-Harm ▢ Loneliness

▢ Suicidal Ideation ▢ Racing Thoughts ▢ Shortness of Breath ▢ Feeling paranoid ▢ Restlessness/Shakiness

▢ Relationship Issues ▢ Difficulty Functioning at home, work, or school ▢ Hopelessness ▢ Headaches

▢ Withdrawn/Isolated ▢ Hearing/Seeing things that aren't there ▢ Intrusive thoughts ▢ Flashbacks/Nightmares

▢ Restricting or Binge Eating ▢ Other (List)____

Do you exercise regularly: ▢ Yes ▢ No How often?: ____

Do you drink alcohol: ▢ Yes ▢ No How often? ____

How many drinks do you have? ________ per ▢ Year ▢ Month ▢ Week ▢ Day

Is drinking alcohol a problem for you? ▢ Yes ▢ No If YES, please describe: ________________________________

____

Do you use recreational drugs? ▢ Yes ▢ No If YES, please describe: _____________________________________

____

Family Mental Health History:

Is there a history of mental health issues in your family? ▢ YES ▢ NO

If YES, please list what and who. ____

____

Please indicate stressors/traumas experienced within the last 2 years:

▢ Own Divorce ▢ Others' Divorce ▢ Loss of significant relationship ▢ Job Loss ▢ Homelessness

▢ Death of immediate family member ▢ Health Issues ▢ Loved One Health Issues ▢ Financial Stress

▢ Domestic Violence ▢ Sexual Abuse ▢ Chronic Illness ▢ Legal Issues ▢ Work Stress ▢ Fertility Issues

▢ Miscarriage ▢ Serious Accident ▢ Separation from child/parent ▢ Witnessing a trauma ▢ Terminal Illness

▢ Bullying ▢ Poor School Performance ▢ Serious Injury ▢ Incarceration ▢ Addiction of Loved One

▢ Incarceration of loved one ▢ Victim of Discrimination ▢ Harassment ▢ Stalking/Threats ▢ Caregiver Stress

▢ Witnessed Traumatic Event ▢ Victim of Violence ▢ Sexual Assault ▢ Severe Mental Illness

▢ Mental Illness of Loved One ▢ Child with disabilities ▢ Unexpected Pregnancy ▢ Military/1st Responder

▢ Other: ____

Family Background:

Mother: Name: ______________________________________Age (or age at death): _________Living: ▢ Yes ▢ No

Father: Name: ______________________________________Age (or age at death): _________ Living: ▢ Yes ▢ No

Current Relationship Status: ▢ Single ▢Married ▢ Separated ▢ Divorced ▢ Widowed

▢ Committed Relationship ▢ It's Complicated

Name of Partner: _________________________________ Length of Relationship:_______________________

Patient Name: _______________________________________

Children:(Names/ages)____

____

Who lives with you?____

____

Current Employment: ▢ None ▢ Full Time ▢ Part Time ▢ Leave of Absence ▢ Retired ▢ Homemaker

Company Name: ______________________________ Position: __________________

Length of Employment: ______________

Job Satisfaction: ▢ I love my job ▢ It's just okay ▢ It's just a job, not a career. ▢ Eh, I don't love it.

▢ Worst job ever. ▢ Depends on the day. ▢ Not sure.

Education: ▢ High School/GED ▢ Some College ▢ Associates ▢ Bachelors

▢ Master's Degree ▢ Doctorate ▢ Other: ____________________________________

What high school did you attend? ____

Did you like it? ▢ Best years of my life. ▢ Eh, it was okay. ▢ School is really not my thing.

▢ Worst years of my life. ▢ Other: _____________________________________

Grades: ▢ Straight A's ▢ A's and B's ▢ Some C's ▢ Didn't I say school isn't my thing?

Social Life: ▢ I was friends with everyone. ▢ Small/Medium size group of good friends

▢ I wasn't a fan of people I went to school with. ▢ I was more of a loner. ▢ I had a friend or two but nothing serious.

What College did you attend? ____ Major: _________________________

Did you like it? ▢ Best years of my life. ▢ It was/is just okay. ▢ Not sure. ▢ Unbearable.

Are you religious/spiritual? ▢ Yes ▢ No If so, what is your religion? _______________________________________

Hobbies/Interests: ____

What are your goals for counseling? ____

____

____

What else would you like us to know about you? ____

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