Phoenix Behavioral Health Services, LLC

3120 Memorial Drive Two Rivers, WI 54241 (920) 657-1780 FAX (920) 657-1784 www.phoenixbhc.com

Intake and Assessment

Please complete the following to the best of your ability.

Name _____ **Age** _____ **Birth date** _____

Presenting Problem

State in your own words the nature of the problem you are seeking help for: _____

_____

_____

When did the problem begin? (Approximate dates and circumstances): _____

_____

_____

What do you hope to accomplish through the counseling process?

_____

_____

Lifestyle Behaviors – Briefly describe:

Eating habits (i.e. frequently overeat, erratic, on a diet...) _____

_____

Sleep/Rest Patterns (how much, restful, toss & turn) _____

_____

Physical Exercise (how much, what kind) _____

Use of Alcohol (frequency, how much, what kind) _____

_____

Use of Other Drugs (frequency, how much, what kind) _____

_____

Caffeine Intake (how much, in what) _____

_____

Smoking (how much) _____

Current Concerns. Please circle any area where you think you may have a PROBLEM:

Anger/Temper	Anxiety/Nervousness	Stress/Burnout	Parenting Skills	Gambling Problem
Fears/Phobias	Behavior Problems	Work/Job/Career	Self-Concept	Recurring Nightmares
Indecision	Relationships	Depression	School Problems	Hopelessness
Irritability	Marital Problems	Suicidal Thoughts	Weight Loss/Gain	Finances/Money
Mood Swings	Sexual Problems	Menopause	Menstrual Problems	Self-Injury
Memory	Concentration	Hyperactivity	Alcohol/Drugs	Guilt

Other: _____

Personal History

Name _____ **Age** _____ **Birth date** _____

Ethnicity _____ **Do you have any Spiritual variables that may impact treatment?** Yes No

If Yes, Please explain _____

Marital Status

Single _____ Engaged _____ *How long?* _____ Married _____ *How long?* _____
Widowed _____ *Date* _____ Divorced _____ *How long?* _____

Children (List names and ages)

_____

_____

Parents

Mother _____ Age _____ Occupation _____

Deceased _____ Age of death _____ Cause of death _____

Father _____ Age _____ Occupation _____

Deceased _____ Age of death _____ Cause of death _____

Brothers and Sisters (List name(s) from oldest to youngest)

_____

_____

Who lives in your home? _____

Work

What is your present occupation or job title? _____

How long have you been employed with your present employer? _____

Do you like your job? _____

Recreation & Leisure

What are your personal hobbies and/ or interest? _____

_____

How often do you involve yourself in your hobbies and other interests? _____

How often do you vacation? _____

Education

Highest grade completed _____ Degree(s) completed _____

Did you have academic, behavioral, or social difficulties in school? _____ Explain: _____

_____

_____

_____

Strengths in school: _____

_____

PHYSICAL HEALTH AND SYMPTOMS

Do you have any concerns about your physical health? Please Explain:

_____

_____

Do you have or been recently exposed to an infectious and or contagious disease? YES NO

If yes, please explain _____

Are you currently under the care of a physician for treatment of a physical or emotional condition? _____

If yes, please list physician's name, reason for treatment, and date last seen _____

_____

Current Physician _____

Last Examination and Results: _____

Please check any of the following that apply to you or a family member (currently or in the past):

	You	Others		You	Others
Thyroid Disease	_____	_____	Infectious Disease	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
Asthma	_____	_____	Hypoglycemia	_____	_____
Allergies	_____	_____	Cancer	_____	_____
High Blood Pressure	_____	_____	Pulmonary Disease	_____	_____
Neurological Disease	_____	_____	Glaucoma	_____	_____
Prostate Problems	_____	_____	Gastrointestinal	_____	_____
Heart Disease	_____	_____	Epilepsy	_____	_____
Premenstrual Syndrome (PMS)	_____	_____	Sleep Disorder	_____	_____
Abortion/Miscarriage	_____	_____	Alcohol/Drug Problem	_____	_____

Other: _____

Please check any of the following that apply to you:

	Never	Occasionally	Often	Very Often
Marijuana	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Narcotics	_____	_____	_____	_____
Painkillers (Aspirin, Tylenol, ect)	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Speed	_____	_____	_____	_____
Gambling	_____	_____	_____	_____
Overeating	_____	_____	_____	_____
Tension	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Hyperventilation	_____	_____	_____	_____
Restless Sleep	_____	_____	_____	_____

MENTAL HEALTH

Have you ever been in counseling or received any form of professional help for your problems: _____

With Whom? When? _____

_____

Was previous counseling or treatment helpful? (Explain) _____

_____

Any history of psychiatric hospitalizations (dates & reasons) _____

_____

Any history of traumatic experiences of any nature? _____

_____

Please check any of the following that often apply to you:

Anger	_____	Tired	_____	Peaceful	_____	Annoyed	_____	Guilty	_____	Bored	_____
Sad	_____	Happy	_____	Restless	_____	Depressed	_____	Hopeless	_____	Tense	_____
Anxious	_____	Hopeful	_____	Lonely	_____	Energetic	_____	Regretful	_____	Content	_____
Fearful	_____	Helpless	_____	Excited	_____	Envious	_____	Relaxed	_____	Joyful	_____
Optimistic	_____	Frustrated	_____	Pessimistic	_____						

List three things you worry about the most:

_____

_____

_____

When do you feel the most calmed and relaxed? _____

_____

How would you like to feel? _____

What do you imagine your life looking like when the problem that brought you here is taken care of?

_____

_____

Marriage/Intimate Relationships

How long have you been married? _____ (or) in a present relationship? _____ Partner's age? _____

Describe your partner's health: _____

Describe your partner's hobbies: _____

What do you like most about your partner? _____

What do you like least about your partner? _____

Describe any problems you see currently affecting your relationship: _____

_____

_____

To what extent can you depend on your partner for support (emotional and/or financial)? _____

_____

_____

List previous relationships/marriages and the reason for their ending: _____

_____

_____

Signature:_____ Date: _____