Exceptional Minds Counseling, LLC
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Client's Name: _____ *Date of birth:* _____

Age: _____ *Gender:* _____ *Marital Status:* _____

Address: _____
Street Address

_____ _____ _____ _____
City *State* *Zip* *County*

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____
Preferred contact #: (circle which phone on above line)

Email Address: _____

Occupation/Company: _____

Partner's Information or Parent's Information (If Young Adult):

Name: _____ *Date of birth:* _____

Relation to Patient: _____ *Gender:* _____

Occupation/Company: _____

Address (*If different from patient's):*
_____
Street Address

_____ _____ _____ _____
City *State* *Zip* *County*

Home Phone: _____ *Cell Phone:* _____ *Work Phone:* _____
Preferred contact #: (circle which phone on above line)

Emergency Contact: (*If no partner or parent listed above)*

_____
Name *Phone #*

INTAKE INFORMATION
Adult Form

Patient Name: _____ DOB: _____ Date: _____

Please list CURRENT family members (Children, Partners, Others you may live with)

Name	*Relation to Patient*	*Age/DOB*	*Do they live with you?*

Please list family whom you grew up with (family of origin/If different than above))

Name	*Relation to Patient*	*Age/DOB*

Past and current marriages:

Names	*When married/how long*	*Divorced/Separated/Together*

Past Mental Health Treatment History (Including Drug/Alcohol Treatment): (*Please check the boxes below if you have had any of the following kind of mental health treatment)*

___ None *___ Outpatient Counseling* *___Psychiatric Hospitalization*
___Psychological Testing *___ Partial Hospital Program* *___Residential Treatment*
___Psychiatric Medication *___Support Group* *___Unknown*

Mental Health Provider or Name of Hospital/Program	*Dates of Treatment*	*Reason for Treatment or Admission*

Family Mental Health History: *Please check yes next to the boxes below if you or any family member (including self, parents, children, spouse, aunts, uncles, grandparents, etc) have had any of the following problems currently or in the past.*

	Yes	*No*	*Maybe?*	*What family member (s)*
Depression				
Anxiety				
ADHD				
Bipolar Disorder				
Schizophrenia/Psychosis				
Eating Disorder				
Learning Disability				
Intellectual Disability				
Autism Spectrum/Aspergers				
Sexual Abuse				
Physical Abuse				
Domestic Violence				
Arrested, Probation, Jail				
Alcohol/Drug Abuse				
Tragic Death				
Suicide/Suicide Attempts				
Panic Attacks				
Psychiatric Hospitalization				
Trauma experience				
Other:				

History of Physical, Sexual, or Emotional Abuse: *(Please include age(s) the abuse occurred, what happened, who was involved)*

_____
_____
_____
_____
_____

Physical Health (Past and Current)

Note: I am not a Physician. For medical problems you need to seek help from your doctor. *Sometimes physical illnesses can cause emotional difficulties, and emotional problems can aggravate physical problems. I have found it helpful to have you answer the following medical questions. Sometimes contact your primary care physician may be beneficial, but this would only happen with your signed authorization.*

Patient's current Primary Care Physician: _____
Name

_____
Street Address *City* *State* *Zip*

_____ _____
Phone Number *Fax Number*

When was the last time you were seen by a medical doctor, and for what reason?

_____
_____

Please check if you have ever had any of the following and then provide more details on the lines below:

_____*High blood pressure*
_____*Low blood pressure*
_____*Diabetes*
_____*Asthma*
_____*Cancer*
_____*Sexually Transmitted Disease*
_____*Seizures*
_____*Thyroid Problems*
_____*Bowel Disorders*
_____*Stomach Disorders*
_____*Heart Disease*
_____*Arthritis*
_____*Allergies*
_____*Sight Problems*
_____*Hearing Loss*
_____*Severe or frequent Headaches*
_____*Immune Deficiency Disorder*
_____*Head Injury*
_____*Ulcers*
_____*Other health problem*

More information on above checked items*:* _____
_____
_____
_____

Previous hospitalizations/or surgeries*:* _____
_____

Female patients**-** *Have you ever been pregnant? _____ If yes, how many times? _____ How many births? _____ Any problems with mood, severe cramps, or irregular cycles?*

_____

_____

_____

Do you have a Gynecologist/or OB? (*If yes, include name/phone #): _____*

_____

Medication/Drug Use History:

Please list below any CURRENT prescribed medications you or an immediate family member is currently taking.

Name of Medication	*Current Dosage*	*How long?*	*Patient*	*Family Member*

PAST Prescribed Psychiatric Medications of patient and/or immediate family:

Name of Medication	*Dosage*	*When/How long?*	*Patient*	*Family Member*

Are you allergic to any medicines or ever have a bad reaction to any medicines*?*

_____

_____

_____

***Present and Past Illicit Drug Use* of patient and/or immediate family member:**

Name of Drug	*How often/How much*	*When*	*Patient*	*Family Member*

Please describe any past or current problems you or your spouse, parents, or other relatives have had with alcohol or drugs?

_____

_____

On average how many cups of caffinated drinks do you drink per day?

_____

Do you smoke cigarettes? _____ How much? _____
Use other tobacco product? _____ How much? _____

Education (History and Current) *Including High school and College.*

Names of schools/ Colleges attended	*Years attended /Degree Earned*

***Types of Education attended*: ___*Regular* ___*Learning Disability (LD)*___ *Intellectual Disability* ___*Multiple Handicapped (MH)* ___*Emotional/Behavior Handicap* ___ *Autism* ___*Vocational* ____*Home schooled* ___*Gifted/AP* ___*Unknown* ___ *Other.*
Current Grades: ___*Average* ___*Above Average* ___*Below Average* ___*Failing* __*N/A*
***Past Grades*:** ___*Average* ___*Above Average* ___*Below Average* ____ *Failing*
***Highest Grade/Degree Completed*:** _____

Legal History (Please describe any current or history of arrests, jail/prison time, DUI, probation, Custody issues):

_____
_____
_____
_____
_____
_____

Current Functioning: *(Please put a check next to the items that apply during past 3 months)*

Sleep: *___Trouble falling asleep ___Trouble staying asleep ___Trouble waking up*
___Insomnia ___Excessive Sleep ___Nightmares ___Sleep Walking
___Irregular sleeping pattern ___ Scared to sleep alone ___None

_____
_____

Appetite *(In past 3 months*): *___Increase ___Decrease ___ No Change*
Any weight gain or loss? How much? _____
___Gorging/Binging ___Vomiting ___Fasting ___Laxative Use ___Other.

_____
_____

Current Relationships:
Describe relationships with friends:

_____
_____

Describe relationship with Partner/Spouse/Significant other:

_____
_____

Describe relationships with Parents:

_____
_____

Describe relationships with co-workers/supervisors

_____
_____

Please describe current involvement in sports, hobbies, clubs, community activities:

_____
_____
_____
_____
_____
_____
_____

Please check the following that apply and then give more detail on the lines below:

___History of suicide attempts
___Past thoughts about wanting to die.
___Current thoughts about wanting to die.
___Have currently thought about plans for suicide.
___History of cutting on self or harming self.
___Current self harming behaviors (cutting etc.)
___History of thoughts or behaviors involving harming others.
___Current thoughts about harming others
___Any recent incidents of harming others
___Current or past behaviors that put yourself at risk or in danger.

Explain:_____
_____
_____
_____
_____
_____

Please describe if there are any religious, cultural, or ethnic influences in the Family that would be beneficial for therapist to be aware of:
_____
_____
_____

Describe at least three strengths or positive qualities about yourself: _____
_____
_____
_____
_____

Please list at least three improvements you would like to see happen for you and your family after coming to therapy:
*1.*_____
_____
*2.*_____
_____
*3.*_____
_____

How long do you estimate it may take to reach the above goals in therapy? *(Please circle)*

1-3 sessions *4-10 sessions* *3-6 months* *6 months- 1 year* *Longer than 1 year*

Do not know *Other:* _____

Please describe any additional information that you think would be important for me to know about you or your family:

_____ _____

Your Signature *Date*