ANCHOR COUNSELING & WELLNESS, LLC

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**Intake**

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. Identification**

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_  
Nicknames or aliases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Home street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_  
Home/evening phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_Male \_\_\_Female \_\_\_Transsexual

Sexual Orientation: \_\_\_Straight \_\_\_Lesbian \_\_\_Gay \_\_\_Asexual

**B. Chief concer**n  
**Please describe the main difficulty that has brought you to see me**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**C. Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:  
When? From whom? For what?

Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When? From whom? Which medications? For what?

**D. Religious and racial/ethnic identification**

Current religious denomination/affiliation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. Your medical care:** From whom or where do you get your medical care?

Clinic/doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

**F. Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**G. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**H. Abuse history:**

❑ I was not abused in any way. ❑ I was abused in the past. ❑ I am currently being abused.

**I. Present relationships**

1. How do you get along with your present spouse or partner, if applicable?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. How do you get along with your children, if applicable?

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**J. Chemical use**

1. How many cups of coffee do you drink each day? \_\_\_\_\_ Tea? \_\_\_\_. How many sodas with caffeine? \_\_\_\_ How many “energy drinks”? \_\_\_\_ How often do you use No Doz or similar caffeine pills? \_\_\_\_\_\_\_ .

2. How much tobacco do you smoke or chew each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning “eye-opener”? ❑ No ❑ Yes

7. How much beer, wine, or hard liquor do you consume each week, on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you ever used inhalants (“huffing”) such as glue, gasoline, or paint thinner? ❑ No ❑ Yes

9. Which drugs (not medications prescribed for you) have you used in the last 10 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**K. Legal history**

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes.

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes. If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. Are there any other legal involvements I should know about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Brief Health Information**

**L. History**

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and

injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical

conditions you have had.

Age Illness/diagnosis Treatment received Treated by Result\_\_\_\_\_\_\_\_\_\_\_\_

List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the­counter vitamins, herbs, and others.

Dose (how

Medication/drug much?) Taken for Prescribed and supervised by\_\_\_\_\_\_

**M. Health habits**

1. What kinds of physical exercise do you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. Do you try to restrict your eating in any way?

How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are there any other medical or physical problems you are concerned about? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**Adult Checklist of Concerns**

Please mark all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.

❑ Aggressive Behaviors

❑ Agitation

❑ Anorexia

❑ Appetite Disturbance

❑ Bingeing/purging

❑ Conduct Problems

❑ Delusions

❑ Depressed Mood

❑ Dissociative States

❑ Elevated Mood

❑ Elimination Disturbance

❑ Emotional Trauma Perpetrator

❑ Emotional Trauma Victim

❑ Fatigue/low energy

❑ Generalized Anxiety

❑ Grief

❑ Guilt

❑ Hallucinations

❑ Hopelessness

❑ Hyperactivity

❑ Irritability

❑ Laxative/Diuretic Abuse

❑ Loose Associations

❑ Mood Swings

❑ Obsessions/Compulsions

❑ Oppositional Behavior

❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Panic attacks

❑ Paranoia

❑ Phobias

❑ Physical Trauma Perpetrator

❑ Physical Trauma Victim

❑ Poor Concentration

❑ PTSD

❑ Self-mutilation

❑ Sexual Dysfunction

❑ Sexual Trauma Perpetrator

❑ Sexual Trauma Victim

❑ Significant weight gain/loss

❑ Sleep Disturbance

❑ Social Isolation

❑ Somatic Complaints

❑ Substance Abuse

❑ Worthlessness

❑ Career concerns

❑ Childhood issues (your own childhood)

❑ Confusion

❑ Custody of children

❑ Decision making, indecision,

❑ Divorce, separation

❑ Drug use

❑ Failure

❑ Financial or money troubles,

❑ Friendships

❑ Gambling

❑ Headaches

❑ Health, medical concerns,

❑ Interpersonal conflicts

❑ Impulsiveness, loss of control,

❑ Irresponsibility

❑ Judgment problems, risk taking

❑ Legal matters, charges, suits

❑ Loneliness

❑ Marital conflict

❑ Memory problems

❑ Menstrual problems

❑ Motivation, laziness

❑ Nervousness, tension

❑ Pain, chronic

❑ Parenting, child management,

❑ Perfectionism

❑ Pessimism

❑ Procrastination, work inhibitions, laziness

❑ Relationship problems (with friends, with relatives, or at work)

❑ School problems

❑ Self-centeredness

❑ Self-esteem

❑ Self-neglect, poor self-care

❑ Sexual issues

❑ Shyness

❑ Smoking and tobacco use

❑ Spiritual, religious, moral issues

❑ Stress

❑ Suspiciousness, distrust

❑ Suicidal thoughts

❑ Temper problems, self-control,

❑ Thought disorganization and confusion

❑ Threats, violence

❑ Withdrawal, isolating

❑ Work problems, employment

