

SANDRA DONALDSON, MDIV. DMIN.
Pastoral Counseling & Marriage & Family Therapy
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CLIENT INTAKE FORM

Name _____ Date _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Work _____ Cell _____

Email (if I may contact you by email) _____ Date of birth _____

Who referred you? _____

Occupation/Employer _____ How long? _____

Are you: (please circle)

Single Married/Permanent Partner Divorced Widowed Living Together Separated

If you are in a relationship, how long have you been in it and what is the quality of the relationship?

If divorced or separated when did this occur and for what reason?

If widowed, please explain your loss, when it happened, and the circumstances around the death.

Who else lives in your household? (Name, age, gender)

Emergency contact:

Name _____ Relationship _____ Phone _____

Have you ever seen other therapists or mental health counselors before? Y N

Who?

What brings you to therapy at this time?

If your reason for coming to therapy is grief/loss /life transition related, and not covered above, please describe it here. Explain as much as you are able. Feel free to use the back of the paper if you would like to add more.

Have you seen another therapist for this **current** problem before? What have you already tried to do about the problem? Has any of it helped?

What are your fears about therapy? What are your hopes and expectations?

Do you have a good support system or circle of friends?

How much do you **currently** drink alcohol, use drugs, smoke various things, etc? If so what and how much a day? Is your alcohol or drug use a problem **for you** or has **someone else** said they think it is a problem for you and are concerned about your use? Please explain as much as you can. Feel free to use the back of the paper. If you or someone else thinks it is a problem, is there something you would like to do about it?

Are you in any kind of a recovery program for alcohol, drug or other addictions, eating disorders, sex addiction, porn, gambling, shopping, relationships, codependency, smoking or any other addiction or something like an addiction? If yes, how long, and what is the quality of your recovery program? What recovery program are you in? Are you working with a sponsor or involved in a self-help group for support?

Do you have a history of having **any kind** of abuse **done to you**? (Physical, sexual, verbal, emotional, spiritual, etc?) Please explain as much as you are able. Have **you** ever abused anyone? Explain as much as you are able. Is there any **current abuse** being done to you, by you or being done in your household? Be honest as it will affect our work together. Feel free to use the back of the paper.

Is there **any** history of any **addiction, abuse, or mental illness** in your family of origin or the family that raised you? If yes, please describe.

Have you ever felt or acted suicidal? Have you been hospitalized for this? **Do you feel this way now?** Do you have a plan? Do you have the means to carry it out? Please explain.

Please describe your spiritual beliefs or practices if any. (Anything from meditation, journaling, walking in nature, to formal religious practice and going to church...whatever you consider spiritual, but not drug or alcohol induced). Does your spiritual practice help you cope with life stressful life events?

How is your current physical health?

What significant illness, surgeries, or hospitalizations have you had? Please list.

Have you had any other kind of trauma that has not been covered in other information already asked? Please describe. (A trauma is what you consider traumatic, not what the general population might consider traumatic. It could be a car accident, a horrible argument, or anything that is painful or shameful, where you felt you were in danger, you felt your life was threatened or you have had recurring intruding thoughts about something that was painful, shameful, frightening, threatening or dangerous, etc). Please include instances of bullying, name calling, horrible teasing, being shamed in public, etc. If you need to, use the back of the paper.

What do you do for fun, entertainment, exercise, relaxation?

What medications are you taking and the reason for them? (Please list especially medications such as: antidepressants, mood stabilizers, and anxiety medications, etc.).

Please list other health care practitioners you are currently seeing or with whom you consult and why.

Please **circle** any of the following words that describe you now:

ACTIVE	AMBITIOUS	MOODY	SELF-CONFIDENT
PERSISTENT	NERVOUS	HARDWORKING	INPATIENT
IMPULSIVE	OFTEN-BLUE	EXCITABLE	IMAGINATIVE
SERIOUS	KINDLY	CALM	EASY-GOING
SHY	GOOD-NATURED	QUIET	INTROVERT
EXTROVERT	LIKEABLE	LEADER	LONELY
SUBMISSIVE	HARDENED	HAPPY	REGIMENTED
SPIRITUAL	REGIMENTED	SELF-CONSCIOUS	SENSITIVE
FEARFUL	ANXIOUS	SAD	

Is there anything else that would be helpful for me to know as we start therapy? Anything about what motivates you? Your learning style? How you cope with new information? What helps you when you are frightened? What you need from me as your therapist? Whatever crosses your mind that you think is useful for our time together...please add.