P.O. Box 581 · Laurel, MD 20725
Phone: (301)490-3825 · Fax: (301)490-3827

Mini Confidential Intake

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Name: ____

Address: ____

City: ____________________ State: ____________________ Zip: __________

Telephone number(s) you want to be contacted at:

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________

Social Security #: ____________ Gender: ____________ Age: ________ DOB: __________

Who referred you? ____

Who should we contact in an emergency? Name: ______________________________

Relationship: ____________________ Address: ____________________

____

Telephone: ____

Significant relationship status (check one):

☐ single (never married) ☐ divorced
☐ engaged ☐ remarried

Check the appropriate box if you want Christian Counseling ☐ Yes ☐ No

Do you regularly attend a church, synagogue, or other religious institution? ☐ Yes ☐ No
If yes, which one? ____

Describe your participation: ____

CHIEF COMPLAINT (Check All That Apply to You):

☐ Depression
☐ Low Energy/Fatigue
☐ Low Self-esteem
☐ Poor Concentration
☐ Hopelessness
☐ Worthlessness
☐ Guilt
☐ Trouble Sleeping/Sleep Too Much
☐ Loss of Appetite/Overeating
☐ Grief/Loss
☐ Mood Swings
☐ Isolation/Social Withdrawal
☐ Apathy
☐ Stress
☐ Anxiety/Panic

☐ Feeling that you are not real
☐ Feeling that things around you are not real
☐ Nightmares
☐ Unpleasant thoughts won't go away
☐ Anger/Frustration
☐ Easily Agitated/Annoyed
☐ Impulsive Behavior
☐ Argues/Blames Others
☐ Alcohol/Drug Abuse
☐ Prescription Abuse
☐ Laxative/Diuretic Abuse
☐ Emotional Abuse Issues
☐ Physical Abuse Issues
☐ Sexual Abuse Issues
☐ Spousal Abuse Issues

☐ Fear of going crazy
☐ Phobias
☐ Racing Thoughts
☐ Anorexia/Bulimia
☐ Excessive Behaviors (spending, gambling)
☐ Obsessions/Compulsions
☐ Can't hold onto an idea
☐ Delusions
☐ See things others don't
☐ Hearing Voices
☐ Not thinking clearly/confusion
☐ Sexual Problems
☐ Marital Problems
☐ Other Relationship Problems
☐ Career/Work problems

PRESENTING PROBLEM/CHIEF COMPLAINT DESCRIPTION

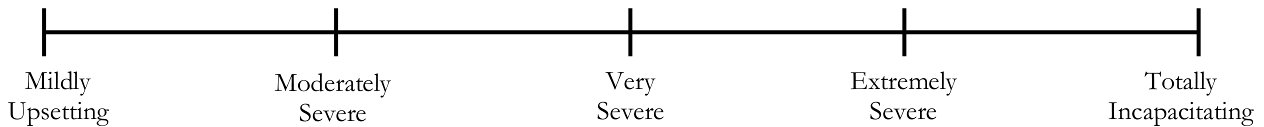
State in your own words the nature of your main problem(s) and a brief history of your complaint(s) from onset to present:

____

____

____

On the scale below, please use an "X" to indicate the severity of your problem(s):



A. Were you hospitalized because of mental illness in the last year? ☐ Yes ☐ No

B. Have you attempted suicide or homicide in the last year? ☐ Yes ☐ No

a. If yes, how many times ________________

C. Are you currently feeling suicidal or homicidal? ☐ Yes ☐ No

a. If yes, do you have a plan? ☐ Yes ☐ No

b. If you have a plan, please describe it: ______________________________________

c. Do you have the means to carry out your plan? ☐ Yes ☐ No

d. If yes, please explain: ____

MEDICATION COMPLIANCE

A. If you are presently taking psychotropic medication(s) please list each one below:

Name	Dosage	Frequency

B. Do you know your medication schedule? ☐ Yes ☐ No

C. Do you think the medication is helping? ☐ Yes ☐ No

D. Do you experience any side effects? ☐ Yes ☐ No

If yes, describe symptoms: ____

Are you currently receiving any medical treatment? ☐ Yes ☐ No

If yes, please describe: ____

Please list any non-psychotropic prescription and over-the-counter medications you are currently taking and the reasons for taking them. (List even if you seldom use or take only as needed.)

Name of Medication(s)	Dose/Schedule	Reason for Taking

Are you taking these medications according to the doctor's recommendations? ☐ Yes ☐ No
If no, please explain: ____________________

Date and outcome of last physical exam: ____________________

What is your height?__________ What is your weight? ________ Describe any regular exercise regimen:
____

Describe your substance use in the last year:

Name of substance(s) used ____________________

Frequency/Amount used ____________________

____

TREATMENT EXPECTATIONS & GOALS

1. What is there about your present behavior that you would like to change? ____________________

   ____

2. How would your life be different if you did not have the difficulties described previously? ____________________

   ____

3. What do you hope to accomplish from therapy, and how long do you expect therapy to last? ____________________

   ____

4. Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you (List any additional problems or difficulties here): ____________________

____

Client's Signature: ____________________ Date: ____________