mundos latinos
COUNSELING & TRAINING

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INITIAL INTAKE

PERSONAL INFORMATION

Name:_____ Date:_____

Parent/Legal Guardian (if under 18): _____

DOB: _____ Age: _____ Gender: _____

Address:

_____

Home Phone: _____ May we leave a message? Yes ◯ No ◯

Phone: _____ May we leave a message? Yes ◯ No ◯

Email: _____ May we leave a message? Yes ◯ No ◯

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Martial Status:

◯ Never Married ◯ Domestic Partnership ◯ Married

◯ Separated ◯ Divorced ◯ Widowed

Referred By (if any): _____

HISTORY

Have you previously received any type of mental health service (psychotherapy, psychiatric services, etc.)? ◯ No ◯ Yes

Previous practitioner & dates: _____

_____

Are you currently taking any prescription medication? ◯ Yes ◯ No

If yes, please list medication and prescribing physician:

_____

_____

GENERAL AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle one)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle one)

POOR UNSATISFACTORY SATISFACTORY GOOD VERY GOOD

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you exercise & what type of exercise?

_____

4. List difficulties you experience with your appetite or eating problems:

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?

◯ No ◯ Yes

For approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias?

◯ No ◯ Yes

When did you begin experiencing symptoms?

_____

7. Are you currently experiencing any chronic pain? ◯ No ◯ Yes

If yes, please describe:

_____

_____

8. Do you drink alcohol? ◯ No ◯ Yes

How many drinks per week?

_____

9. How often do you engage in recreational drug use?

◯ Daily ◯ Weekly ◯ Monthly ◯ Infrequently ◯ Never

10. Are you currently in a romantic relationship? ◯ No ◯ Yes

If yes, how long? _____

On a scale of 1-10 how would you rate your relationship? Please circle one.

1 2 3 4 5 6 7 8 9 10

POOR EXCEPTIONAL

11. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

ADDITIONAL INFORMATION

1. Are you currently employed? ◯ No ◯ Yes

If yes, what type of job do you do?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ◯ No ◯ Yes

If yes, describe your faith or belief:

_____

3. What are some of your strengths?

_____

_____

4. What are some of your weaknesses?

_____

_____

5. What are some of your goals for your time in therapy?

_____

_____