WISDOM THERAPY INSTITUTE CLIENT INTAKE FORM

Name _____ Age_____

Home Phone (_____)_____(message: Y/N)

Work Phone (_____)_____(message: Y/N)

Cell Phone (_____)_____(message: Y/N)

Email Address _____

Address _____

City_____ Zip_____

Date of Birth _____ Gender (M/F)

Referral Source _____

Reason for Referral _____

Emergency Contact (1): Name & Relationship_____

Phone (_____)_____

Emergency Contact (2): Name & Relationship_____

Phone (_____)_____

BACKGROUND

Are there any immediate issues that need our attention? Yes/No If yes, please describe.

_____
_____
_____
_____
_____

Have you had previous counseling or psychotherapy? Yes/No From when to when? With whom?

_____
_____
_____
_____
_____

PERSONAL EXPERIENCE

Please check the emotions you have frequently felt recently, or in the past:

_____ Hopeful
_____ Angry
_____ Sad
_____ Grateful/thankful
_____ Happy
_____ Love
_____ Empathy
_____ Anxious/worried
_____ Compassion
_____ Courageous

_____ Afraid
_____ Jealous
_____ Sexual/erotic
_____ Excited
_____ Lonely
_____ Energetic
_____ Relaxed/peaceful
_____ Shyness
_____ Irritability
_____ Other emotions you often feel:

_____ Equanimity
_____ Shameful/guilty
_____ Humor/playfulness
_____ Awe
_____ Loyalty
_____ Friendly
_____ Humility
_____ Boredom
_____ Unhappy

_____
_____
_____

Please mark any of the following experiences you've had recently, or have had at times in the past:

_____ A sense of freedom in your life
_____ Relationship difficulties
_____ Legal difficulties
_____ Career difficulties
_____ Parenting problems
_____ Nightmares
_____ A sense of helplessness
_____ Sexual problems
_____ Needing less sleep than normal
_____ Feeling creative
_____ A sense of hopelessness
_____ Thoughts that you would be better off dead
_____ A sense of responsibility for your life
_____ A sense of curiosity
_____ Thoughts racing through your head
_____ Having much more energy than normal
_____ A consideration of death
_____ A sense you can handle most/all of your experiences
_____ Difficulty concentrating
_____ Desire to harm yourself
_____ Hearing or seeing things not actually there
_____ Thoughts that seem strange but that you can't seem to stop
_____ Fear that someone is trying to harm you
_____ Little interest or pleasure in doing things
_____ Poor or excessive appetite

Please mark any of the following behaviors or bodily feelings that are true of you:
_____ Drink too much
_____ Eat too much
_____ Eat too little
_____ Use illegal and/or mind-altering drugs
_____ Neglect friends and family
_____ Difficulty being kind and loving to yourself
_____ Lose your temper
_____ Seem to not have control over some behaviors
_____ Neglect self and your own needs
_____ Act in ways that end up hurting yourself or others

_____ Have difficulty concentrating
_____ Spend more money than you can afford to
_____ Crying
_____ Any other behaviors you would like me to know about?

_____
_____
_____

_____ Headaches
_____ Menstrual problems
_____ Dizziness
_____ Heart tremors
_____ Jitters
_____ Sexual pre-occupations
_____ Excessive tiredness
_____ Tingling/numbness
_____ Blackouts
_____ Do you have any other bodily pains or difficulties? Yes/No If yes, what are they?

_____
_____
_____

Where in your body do you feel stress (shoulders, back, jaw, etc.)?

_____
_____
_____

What aspects of your life are most stressful to you right now?

_____
_____
_____

What sort of support system do you have (friends, family, religious community, etc. who help you in times of need)?

_____
_____
_____

What is your educational background?

_____
_____

What is your occupation? _____

What is your yearly income? $ per year.

Has anyone in your family ever been given a psychological/psychiatric diagnosis? Yes/No If yes, please describe.

_____
_____
_____

What do you consider to be your strengths?

_____
_____
_____

What are some things you highly value?

_____
_____
_____

Have you ever attempted to seriously harm or kill yourself or anyone else? Yes/No If yes, please describe.

_____
_____
_____
_____

Are you presently experiencing suicidal thoughts? Yes/No If yes, please describe.

_____
_____
_____
_____

Has anyone in your family ever attempted or committed suicide? Yes/No If yes, please describe.

_____
_____
_____

Have there been any serious losses or changes in your family that have affected you? Yes/No If yes, please describe.

_____
_____
_____

Please describe the major changes in your life over the past two years.

_____
_____
_____

Please rate the following questions on a 1-5 scale by circling the number that most closely corresponds to your experience.

In general, how satisfied are you with your life?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1	2	3	4	5

In general, how do you feel about yourself (self-esteem)?

Very Badly	Badly	Neutral	Good	Very Good
1	2	3	4	5

In general, how much control do you feel you have over your life and how you feel?

No Control	A Little Control	Some Control	A Lot of Control	Total Control
1	2	3	4	5

In general, how would you rate your physical health?

Very Unhealthy	Unhealthy	Neutral	Healthy	Very Healthy
1	2	3	4	5

In general, how satisfied are you with your friendships and other relationships?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1	2	3	4	5

In general, how comfortable are you in social situations?

Very Uncomfortable	Uncomfortable	Neutral	Comfortable	Very Comfortable
1	2	3	4	5

In general, how satisfied are you with your religion/spirituality?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1	2	3	4	5

How satisfied are you with the type of work you do?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1	2	3	4	5

How satisfied are you with your standard of living?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
1	2	3	4	5

Please list any medications you are presently taking (dosage/amount and what the medication is for).

_____ _____ _____
_____ _____ _____

Do you have a primary care physician? Yes/No If yes, who is it?

_____

Height _____ Weight _____lbs.

When was your last physical? _____

What other significant medical problems have you experienced or are you experiencing now?

_____
_____

Describe your current sleeping patterns (When do you sleep? How many hours per 24 hrs? Do you sleep straight through or do you wake up during sleep time?).

_____
_____
_____

Do you feel rested upon waking? Yes/No

Do you take vitamins and other nutritional supplements? Yes/No If yes, please describe.

_____
_____

Do you smoke? Yes/No If yes, how much? _____

Do you use caffeine? Yes/No If yes, how much? _____

Describe your drug and alcohol use (both past and present).

_____
_____
_____

Do you engage in some form of exercise (aerobic and/or strength building)? Yes/No If yes, please describe.

_____
_____

Please list the people currently living in your home.

NAME	AGE	GENDER	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list your family of origin (family you grew up with), beginning with the oldest, include parents and yourself. (include “step” and “half” etc.)

NAME	AGE	GENDER	RELATIONSHIP

Do you have a religious/spiritual affiliation and/or practice? Yes/No If yes, please describe.

Are there any groups or organizations that you are affiliated with or would like to be a part of?

Describe your current physical home environment. For example, describe the layout of your home, and other general conditions. (Do you have privacy? well-lighted? A/C? Heating? etc.)

Describe your neighborhood. (Is it safe/dangerous? nice/unpleasant? quiet/loud? etc.)

Describe your current social home environment (how would an outside observer describe how you get along with those who live with you?).

Describe your work environment (include co-workers and supervisors who directly affect you).

Do you have pets? Yes/No How important are they to you?

_____
_____

Have you served in the military? Yes/No If yes, please describe.

_____
_____
_____

Have you had any involvement with the legal system (incarceration, probation, etc.)? Yes/No If yes, please describe.

_____
_____
_____

Do you participate in any volunteer work? Yes/No If yes, please describe.

_____
_____
_____

What do you find most humorous about yourself?

_____
_____

Please mark any of the following that you have experienced difficulties with. Indicate to the right of the problem in the parentheses ( ) the approximate age when the difficulty or problem occurred:

_____ nursing and/or eating ( )
_____ toilet training ( )
_____ crawling or walking ( )
_____ talking ( )
_____ nail biting or other nervous habits ( )
_____ going to school/ separating from caregivers ( )
_____ cruelty to animals or people ( )
_____ serious illnesses or injuries ( )
_____ academic problems ( )
_____ social problems ( )
_____ moves or other family stresses ( )
_____ abuse (emotional, physical, or sexual) ( )
_____ any problems with sexual maturation ( )
_____ being made fun of or joked about at school, home, or elsewhere ( )
_____ self-destructiveness (risky sex, eating problems, drug use, excessive risk-taking, etc.) ( )
_____ fitting into social groups ( )
_____ standing up for what you believe in when it differs from your peers' views ( )
_____ making important decisions, especially when they differ from social norms ( )
_____ any existential dilemmas ( )
_____ any religious and/or spiritual experiences (these could be completely positive) ( )

The following is a list of various parts, aspects or subpersonalities that many people notice within themselves in certain situations, but not in others. Please mark how prevalent these subpersonalities are in you and in what situations you have noticed them. (1 = Never Noticed, 2 = Seldom Noticed, 3 = Regularly Noticed, 4 = Often Noticed, 5 = Always Noticed)

Irresponsible Child
1 2 3 4 5
Situations Noticed: _____

Critical Parent
1 2 3 4 5
Situations Noticed: _____

Dominating "Top Dog"
1 2 3 4 5
Situations Noticed: _____

Prone-to-fail "Underdog"
1 2 3 4 5
Situations Noticed: _____

Overly-harsh Judge or Critic
1 2 3 4 5
Situations Noticed: _____

False or Phony Self
1 2 3 4 5
Situations Noticed: _____

Unworthy, Not-good-enough Self
1 2 3 4 5
Situations Noticed: _____

Grandiose, Better-than-everyone-else Self
1 2 3 4 5
Situations Noticed: _____

If you experience other important subpersonalities not listed, please describe and list below:

Subpersonality: _____
1 2 3 4 5
Situations Noticed: _____

Subpersonality: _____
1 2 3 4 5
Situations Noticed: _____

Subpersonality: _____
1 2 3 4 5
Situations Noticed: _____

Is there anything else you want me to know about? (Use the back of the page if you need to.)