The Connected Self
COUNSELING FOR COUPLES & INDIVIDUALS

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Virtual Telehealth Office
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"FOSTERING CONNECTION WITH YOURSELF AND THE ONE'S YOU LOVE."

Client Intake Assessment

Name: _____ Address: _____

Date of Birth: _____ _____

Age: _____ Email: _____

Preferred Pronouns: _____ Phone Number: _____

☐ Voicemail OK ☐ Text OK

How did you hear about/find this practice?

_____

Is it okay for the clinician to contact your referral source to send a thank you note? ☐ Yes ☐ No

Emergency Contact

Name: _____ Phone Number: _____

Relationship Status:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and other household members.

Name	Age	Relationship to You	Lives in the Home

What are your main presenting concerns or goals for therapy?

_____

_____

_____

_____

Mental Health History

Have you previously received any type of mental health services? ☐ Yes ☐ No

Have you previously visited a behavioral health unit due to a mental health crisis? ☐ Yes ☐ No

If yes, please list previous provider(s): _____

Please list any recent significant life changes and stressors?

_____

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

If yes, please list: _____

Please rate the following:

Self-Esteem	☐ Very Poor	☐ Poor	☐ Average	☐ Good	☐ Very Good
Sleeping Habits	☐ Very Poor	☐ Poor	☐ Average	☐ Good	☐ Very Good
Relationship Satisfaction	☐ Very Poor	☐ Poor	☐ Average	☐ Good	☐ Very Good
Sexual Satisfaction	☐ Very Poor	☐ Poor	☐ Average	☐ Good	☐ Very Good
Relationship to Food	☐ Very Poor	☐ Poor	☐ Average	☐ Good	☐ Very Good

Have you struggled with any of the following:

Depression	☐ Yes ☐ No	If yes, please provide any relevant details:
Anxiety	☐ Yes ☐ No	_____
Substance Use	☐ Yes ☐ No	_____
Chronic Pain	☐ Yes ☐ No	_____
Significant Losses	☐ Yes ☐ No	_____

Employment

Are you currently employed? ☐ Yes ☐ No

Is your work currently a major stressor in your life? ☐ Yes ☐ No

Social & Personal Inventory

Are you connected to any social or cultural communities (e.g. religious or spiritual groups, LGBTQIA+, Native American tribes)? ☐ Yes ☐ No

If yes, please list: _____

Strengths: _____

_____

Areas to Improve: _____

_____

Family & Relationship History

Please complete the following information regarding your family of origin (parents, siblings) and any other significant family members:

Relationship to You	Feelings Toward the Relationship
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative
_____	☐ Positive ☐ Neutral ☐ Negative

In the section below, identify if there is a family history of the following. If yes, please indicate the family member's relationship to you (e.g. mother, grandfather, aunt).

Depression	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Alcoholism or Substance Use	☐ Yes	☐ No	_____
Domestic Violence	☐ Yes	☐ No	_____
Disordered Eating	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Schizophrenia	☐ Yes	☐ No	_____
Suicide Attempts	☐ Yes	☐ No	_____
Other _____	☐ Yes	☐ No	_____

Please list any previous marriages or partnerships and provide a brief description of the relationship:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____