ELEMENTAL COUNSELING & CONSULTING, LLC
CREATING PATHWAYS FOR CONNECTION

Individual/Couple/Family Intake Questionnaire

Primary Client Name:
Address:
Phone:
Email:

Please provide the following information of your immediate family.

Client 1(self):
Name:
D.O.B.:
School:
Employer:
Highest Level of Education/Grade:
Relationship Status/Type of Relationship:

Client 2:
Name:
D.O.B.:
School:
Employer:
Highest Level of Education/Grade:
Relationship Status/Type of Relationship:

Client 3:
Name:
D.O.B.:
School:
Employer:
Highest Level of Education/Grade:
Relationship Status/Type of Relationship:

Client 4:
Name:
D.O.B.:
School:
Employer:
Highest Level of Education:
Relationship Status/Type of Relationship:

Client 5:
Name:
D.O.B.:
School:
Employer:
Highest Level of Education/Grade:
Relationship Status/Type of Relationship:

Do you or your family have a history of emotional problems or psychiatric hospitalizations:
No/Yes
If "Yes", explain: _____
_____
List any major health problems of family members: _____
Do you/anyone in your family take medications: No / Yes
If "Yes", list names, purposes: _____
_____
Have you/anyone in your family ever had legal/court-related problems: No / Yes
If "Yes", please explain: _____
_____
Has drugs/alcohol ever caused problems in your family: No / Yes
If "Yes", please explain: _____
Have you/anyone in your family ever felt like harming themselves/others: No / Yes
If "Yes", please explain: _____
Have you/anyone in your family been a victim of physical/sexual abuse: No / Yes
If "Yes", please explain: _____
Have you/anyone in your family had work or school related problems: No / Yes
If "Yes", please explain: _____

In your own words, what is the primary reason you or your family are seeking therapy: _____
_____
_____
_____
_____

Is there any other information you think your therapist should know? _____
_____
_____
_____

Please list at least one emergency contact person below:

Name	Phone Number	Relationship to You

Primary Care Physician and/or Specialists:
_____
_____
_____

Previous Counseling Experiences:
_____
_____

Adjustment to new or different lifestyles or ways of living:

- ☐ Being divorced or separated
- ☐ Being remarried
- ☐ Living in a remarried family with children
- ☐ Moving to a new location
- ☐ Parenting a newborn
- ☐ Being a single parent
- ☐ Relative or friend in the household
- ☐ Other adjustment(s), please specify

_____

_____

Adult personal, marital or intimate relationship Concerns (Problems related to children should be noted in the two major categories following this section):

- ☐ Grief/mourning following loss
- ☐ Depression/feeling blue
- ☐ Anger or difficulty controlling temper
- ☐ Loneliness
- ☐ Lack of trust
- ☐ Feeling rejected
- ☐ Low self-esteem
- ☐ High anxiety
- ☐ Guilt
- ☐ Midlife crisis/growing older difficulties
- ☐ Physical problem(s)/illness
- ☐ Financial difficulties/stress
- ☐ Poor relationship with adult (not partner)
- ☐ Alcohol or drugs
- ☐ Religion/spirituality
- ☐ Sexual difficulties
- ☐ Sexual identity/sexual orientation concerns
- ☐ Poor communication
- ☐ Arguing or handling conflict
- ☐ Differences in personality
- ☐ Having an affair
- ☐ Amount of time spent together
- ☐ Use of leisure time or share activities
- ☐ The role of men and women
- ☐ Domestic tasks/who does what around the house
- ☐ Emotional abuse of/by partner
- ☐ Physical abuse by/of partner
- ☐ Careers of both partners conflict
- ☐ One partner is domineering/controlling
- ☐ Different expectations about what a relationship should be
- ☐ One or both of us do not feel emotional support
- ☐ One or both of us cannot accept faults in partner
- ☐ One or both of us no longer feel in love
- ☐ One/both of us are jealous of partner's relationship with opposite sex friends
- ☐ Other problems with friends
- ☐ Problems with relative
- ☐ Contact from ex-spouse upsetting our relationship
- ☐ Relationship takes second place to the children
- ☐ Other, please specify _____

_____

Family Problems:

- ☐ One or both of us not spending enough time with family
- ☐ Poor communication in family
- ☐ One of more family member(s) does/do not get along
- ☐ Custody or visitation problems
- ☐ Disagreement with partner about discipline
- ☐ Not sure what to expect of children
- ☐ Don't feel I/we am/are a good parent
- ☐ Physical abuse of child(ren)
- ☐ Fear of abusing child(ren)
- ☐ Sexual abuse of child(ren)
- ☐ Difficulty allowing child(ren) to grow up
- ☐ Other family problem(s), please specify

_____

_____

_____

_____

Child & Teen Problems:

- ☐ Arguing
- ☐ Competiveness
- ☐ Complaining
- ☐ Crying
- ☐ Talking back
- ☐ Fearfulness
- ☐ Fighting
- ☐ Hitting other
- ☐ Irritableness
- ☐ Lying
- ☐ Negativism
- ☐ Not doing chores or assignments
- ☐ Sadness/unhappiness
- ☐ Teasing
- ☐ Bossiness
- ☐ Threatening
- ☐ Whining
- ☐ Yelling
- ☐ Inappropriate attention getting
- ☐ Destructiveness
- ☐ Fire setting
- ☐ Not following rules or curfew
- ☐ Running away
- ☐ Stealing
- ☐ Truancy from school
- ☐ Academic problems
- ☐ Poor peer relations
- ☐ Undesirable friends
- ☐ Bedwetting
- ☐ Wetting pants
- ☐ Soiling pants
- ☐ Not eating properly
- ☐ Obesity
- ☐ Excessive worrying
- ☐ Physical or mental disability
- ☐ Hyper activeness (too active)
- ☐ Drugs or Alcohol
- ☐ Sexual misbehavior or problem pregnancy
- ☐ Sexual identity/sexual orientation concerns
- ☐ Trouble with the law
- ☐ Misusing driving privileges
- ☐ Problems with dating
- ☐ Suicide attempt or talk of suicide
- ☐ Withdraw
- ☐ Difficulty in response to parents' divorce
- ☐ Difficulty with divorced parents' dating
- ☐ Difficulty with parent's new marriage
- ☐ Other child/teen problem(s), please specify:

_____

Looking back over all these problems, if you had to choose ONE problem that was the problem for which you most wanted help; it would be:

_____

_____

_____

I think the outcome of counseling will be successful:

☐ Strongly agree ☐ Agree
☐ Strongly disagree ☐ Disagree
☐ Undecided

How many sessions do you think it will take to resolve the problems that brought you here?

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-15 ☐ 15-20
☐ Over 20 ☐ Undecided

Additional information:

_____
_____
_____
_____
_____
_____
_____

Contact Information:

Elemental Counseling & Consulting, LLC
Address: 140 Wadsworth Road, Wadsworth, OH 44281
Phone: (234)281-2721
Email: nfinney@elementalcc.com