BYKOTA WELLNESS LLC

Intake Form for Adults

Today's Date: _____ Name_____
Your age _____ Date of Birth _____ Gender_____

Address _____
Email address_____ Cell Phone _____

Occupation (s) _____

Who referred you to therapy?
_____

Have you had prior experience in counseling? Yes ( ) No ( ) If yes, please describe with whom, when, how long, and for what:
_____
_____

Please rate your general satisfactions with life a present (circle one)

Very dissatisfied **0 1 2 3 4 5 6 7 8 9 10** very satisfied

What are the three most significant issues you face currently?

1. _____
2. _____

3. _____

Present Marriage (or significant relationship)

Spouse/Partner _____ Age ____ Gender _____ Occupation_____
Years known each other _____ Years married____ Date married _____
Children of this marriage (names/ages) Stepchildren (names/ages)

_____
_____

Have you been married before? ____ If one or more prior marriage(s), please list below (use back of page if more space is needed):

_____
_____

Please rate your level of satisfaction in present marriage/significant relationships

Very dissatisfied **0 1 2 3 4 5 6 7 8 9 10**very satisfied

Family of Origin (Parents & Siblings)

Parents still together _____ Divorced _____ Remarried _____

Mother's name _____Age _____ Occupation _____
Present state of health_____
If deceased, year/cause _____

Father's name _____ Age _____ Occupation _____
Present state of health _____
If deceased, year/cause _____

Step parents

_____
_____

Siblings (Biological and Step): Age, Marital Status, Occupation, Location

_____
_____
_____

How would you rate relationships with your parents generally?
(Scale 1-10) 1 = non-existent & 10 = "best of friends"

Mother: ____ Step-mother: ____ Father: _____ Step-father: _____

Extended and Immediate Family history(please check those which apply and to whom)
Divorce ___ Alcohol/substance abuse ____ Physical abuse ____ Sexual abuse ____
Depression ___Anxiety ___ Suicide ___ Bipolar ___Mental illness (other) ____

Whom does this apply?

_____
_____
_____

Current/Recent Mood (check all that apply as of recently)

Anxiety ___ Fear ___ Sadness ___ Grief ___ Anger ___ Irritability ___ Happy ___ Impatient ___ Calm ___ Numb ___ Suicidal ___
Other_____

Any changes or concerns involving the following?(Please check those which apply)

Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Moving ___
Marital Status ___ Parenting ___ Concentration ___ Memory ___ Energy____
Health/Illness ___ Surgery/Injury ___ Grief/Loss ___ Addition of a Family Member ___ Family Member Leaving Home ___ Sexual Activity ___ Sleep Habits ___ Eating Habits ___

Caffeine Intake ___ Tobacco Use ___ Alcohol Use ___ Drug Use ___ Other _____

Years & Level of Education:
_____ Is Spirituality/Religion important to you? _____ Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( ) _____ Who do you consider as your greatest support?_____
What do you consider your greatest strengths? _____
What do you consider your greatest weakness? _____

How do you rate relationship with yourself generally? (Same scale as above) _____
Additional comments:_____
_____

Is there anything in particular that you want me to know about you or your situation?

_____
_____

Thank you and I look forward to working with you.
CASSANDRA CHANEY, LCSW-C