Spira Counseling Intake Form

Name:____**Date:**___________________________________

Preferred Gender Pronoun:
He/She/They/Other:____

Date of Birth: ___________________ **Email:**____

Phone: _________________________________**Alt. Phone**:____

(Initial) __________ *I authorize Spira Counseling to leave messages on the provided phone number(s).*

Address:____

____

Emergency Contact: ______________________________ **Phone:** _____________________________________

*Emergency contact will only be contacted during an emergency and your information will be protected. Only as much is necessary to the situation will be disclosed, as per your confidentiality agreement. You may change your emergency contact at any point, but must supply an alternative if you choose to do so.

Why are you here for treatment today? Please specify nature of the problem/s, How long you've been struggling with this problem, how frequently it presents itself, and how severe it feels to you:

____

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____

Please identify 2-3 goals that you would like to achieve in counseling:

1. ____
2. ____
3. ____

Please name some of your strengths (examples of strengths include kindness, empathy, strong-will, humor etc.):

____

____

Work History:

What is your occupation?____

Employment Status:____

Social/Cultural History:

What is your marital status?____

Significant relationship/s?____

Do you have any children? Yes No

If yes, what are their ages? ____

Do you have siblings? If so, where do you fall in the birth order?______________________________

____

Have you had a stress, change, or loss in a significant relationship(s) within the past 12 months? Yes/No

If yes, please explain:____

____

____

What is your ethnicity? What are cultural/spiritual factors that most influence you?

____

____

Are you experiencing any unusual stressors? No Yes

If yes, Please explain:

____

____

Living Situation: Live Alone With Family With Friends Homeless Other

Do you feel safe/stable/secure in your current living situation?

____

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Drug Use History:
Information regarding drug use is, in addition to HIPAA, protected under 42 CFR part 2, and will not be disclosed unless you provide written consent that you would like this information disclosed, this written consent can be revoked at any time: Please see privacy policies and release of information documentation for more information.

Has anyone said you have a drugs or alcohol problem? No Yes

Please explain.____

____

Tobacco Use

☐ No - Never ☐ No - Former Smoker ☐ Yes - Occasional smoker ☐ Yes - Smoke every day

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If yes,

Drinks per week: ______Glasses of wine ______Cans or bottles of beers ______Shots of liquor

Recreational Drug Use (not prescribed to you)

Do you use recreational drugs? ☐ Yes ☐ No

If yes,

Drug Type?
- ☐ Benzodiazepines (Xanax, Ativan, Valium)
- ☐ Cannabis
- ☐ Cocaine
- ☐ Methamphetamine
- ☐ Opiates

Use per week ☐1 ☐2 ☐5 ☐Other

In the last 6 months, have you noticed any change in:

eating (circle: increase or decrease)
sleeping (circle: increase or decrease)
mood (circle: increase or decrease)
doing more or less activities than usual
enjoying myself more or less than usual
feeling guilty or shameful
feeling hopeless or helpless

thoughts of harming yourself
feeling restless/ agitated
feeling excessively anxious or worried

Do you have any chronic health problems:

asthma
diabetes
heart disease
sleep apnea
dementia
other ________________
chronic pain (please circle: fibromyalgia, chronic fatigue, TMD, IBS, arthritis, other: ______________)

Do you have thoughts or plans of attempting suicide?

Past: Yes/No

How long ago?____

Current: Yes/No

Attempts: ____

Do you have any thoughts of harming yourself?

Past: Yes/No

How long ago?____

Current: Yes/No

Do you have any thoughts of harming others?

Past: Yes/No

How long ago?____

Current: Yes/No

Is there any other information you would like to provide that you believe will benefit your care?