DEANDA SYLTE ROBERTS

M.A.

COUNSELING INTAKE FORM – PRIVATE AND CONFIDENTIAL

DATE

PERSONAL INFORMATION

FULL LEGAL NAME | DATE OF BIRTH

WHAT YOU LIKE TO BE CALLED | AGE | SSN

STREET ADDRESS | CITY

STATE | ZIP | Yes No OKAY TO MAIL?

EMAIL | Yes No OKAY TO EMAIL?

HOME PHONE | Yes No OKAY TO CALL?

CELL PHONE | Yes No OKAY TO CALL/TEXT?

EMERGENCY CONTACT NAME & PHONE

EMERGENCY CONTACT RELATION TO YOU

REFERRAL SOURCE TO COUNSELING

Please briefly describe the reason you are seeking counseling services and what goals you hope to achieve in therapy:

705 W. Seventh Ave, Ste. 1-C Spokane, WA 99204 DR (509) 624-7252 • sylteroberts@comcast.net

PERSONAL INFORMATION

Please answer the following questions by circling: 5 – Excellent, 4 – Good, 3 – Average, 2 – Poor, 1 – Failing

How would you currently rate your physical health?	1	2	3	4	5
How would you currently rate your mental health?	1	2	3	4	5
If applicable, how would you currently rate your spiritual health?	1	2	3	4	5

Please briefly describe any faith practice you engage in and/or faith community you are a part of:

Do you hope to incorporate faith/spirituality into your counseling process? If yes, please describe how you would like to do so:

PRIMARY CARE PROVIDER

ADDRESS

PHONE

Are you currently under the care of a specialist physician? If yes, please list the following:

SPECIALIST PHYSICIAN NAME

ADDRESS

PHONE

Have you ever or are you currently experiencing difficulties with any of the following health concerns? Please check all that apply:

Asthma		Fibromyalgia		Vision problems	
Allergies		Heart disease		Hearing problems	
Brain/Head Injury		Thyroid disorder		Diabetes	
Digestive concerns		Hearing problems		Seizures	
Respiratory concerns		Multiple sclerosis		Cancer	
High blood pressure		Epilepsy		Headaches	
High cholesterol		Autoimmune complications		Tuberculosis	
Chronic fatigue		Sleep disturbance		Infertility	
Chronic pain		Sexually transmitted disease		Other	

Please briefly explain any check marks above (date, severity of symptoms, current status, etc.):

Please list any prescription medications you are currently taking, including dosage information:

Please list any over the counter medications, vitamins, or supplements you are currently taking, including dosage information:

Are you currently or have you ever been pregnant? _____

NUMBER OF LIVE BIRTHS

NUMBER OF MISCARRIAGES

NUMBER OF ABORTIONS

NUMBER OF ADOPTIVE PLACEMENTS

Please list and provide the approximate date(s) of any surgeries you have had or serious accidents you have experienced:

MENTAL HEALTH HISTORY

Please briefly describe any self-care practices you currently utilize (exercise, mindfulness, etc):

Please list and describe the mental health symptoms you are currently experiencing, beginning with the most distressing:

Are you currently or have you ever been in counseling/therapy before? _____ If yes, please briefly describe your experience (approximate dates and duration of previous counseling, name of practitioner, type of counseling, effectiveness, etc.):

Have you ever been hospitalized for mental health concerns? _____ If yes, please list hospital(s) and length/date(s) of stay:

Have you ever engaged or are you currently engaging in self harm? _____ If yes, please list approximate dates and methods used:

Have you ever contemplated or are you currently contemplating suicide? _____ If yes, please list approximate dates and describe nature of contemplation:

Have you ever attempted suicide? _____ If yes, please list date(s), methods used, and any subsequent treatment received:

Have you ever or are you currently contemplating harming another person? _____ If yes, please explain:

Has anyone in your family or anyone close to you attempted and/or completed suicide? _____ If yes, please explain (person(s), relationship to you, date(s), method(s) used, etc.):

Please indicate substances you use currently (in the past 6 months) or have used in the past, along with amount and frequency of use and age you began using substance:

Substance	Current	Past	Amount/Frequency	Age at first use
Caffeine				
Alcohol				
Tobacco / nicotine / vaping				
Marijuana				
Crack/Cocaine				
Ecstasy				
Heroin				
Methamphetamines				
Sleep medications				
PCP/LSD/Mushrooms				
Pain killers				
Steroids				
Prescription Meds (not prescribed to you)				
Krocodil				
Kratom				
Other				

Do you believe your current substance use is problematic?

Has anyone else ever expressed concern about your substance use?

Have you ever experienced problems with relationships, work, health, the law, etc. due to your substance use? _____
If yes, please explain:

Have you ever participated in drug or alcohol treatment? _____ If yes, please list date(s) location,length, and type of treatment:

FAMILY & RELATIONSHIP HISTORY

Please list the names, ages, and nature of relationship for each person with whom you currently live:

Name	Age	Nature of Relationship

Do you have children? _____ If yes, please list names and ages below (disregard this part if you already listed children above):

Name	Age	Name	Age

Please describe your sexual orientation, gender identity/expression, and preferred pronoun(s):

Are you currently in a romantic relationship? _____ If yes, please list name of person, relationship status, and length of time you have been together:

Were you adopted? _____ If yes, please list your age at time of adoption: _____

Were your parents married? _____ Divorced? _____ If divorced, your age at separation: _____

Please indicate whether you or an immediate family member experienced any of the following:

Event	Self	Other	Relation to you
Emotional abuse			
Physical abuse			
Physical/domestic abuse			
Substance abuse			
Neglect			
Serious illness/accident/injury			
Financial problems			
Frequent/multiple moves			
Legal problems			
Racial/ethnic discrimination			
Discrimination based on sexual preference/gender identification			
Marital infidelity			
Military			
Homelessness			
Other:			

EDUCATION/VOCATIONAL HISTORY

Number of years of formal education completed: _____ Degree(s) achieved (mark all that apply):

High School Diploma		GED		Vocational/Trade School		Associates Degree	
Bachelors Degree		Masters Degree		Doctorate Degree		Other	

Are you currently employed? _____ If yes, please list name of employer, type of work, and length of time at current place of employment:

Have you ever served in the military? _____ If yes, please list branch, rank, deployment(s), and current states (active, discharged):

Please list any personal hobbies or interests:

LEGAL HISTORY

Have you ever been the victim of a crime? _____ If yes, please briefly describe:

Have you ever been convicted of a misdemeanor or felony? _____ If yes, please explain:

Are you currently involved in divorce, child custody, or other legal proceedings? _____ If yes, please explain:

ADDITIONAL INFORMATION

Is there anything else you would like me to know about you prior to the start of therapy that would be helpful in discerning the best course of treatment?