Confidential Intake Form

Max Tsymbalau, MS, LMHC

3417 Evanston Ave N, Suite 307
Seattle, WA 98103

206-206-0752
max@maxcounseling.com

I would like to get some background information about you before we begin working together. If you do not feel comfortable providing certain information at this time, you may leave the corresponding fields blank. Thank you for taking the time to fill out this form.

Today's Date: _____

Name: _____

Date of Birth: _____

Current Address: _____

Permanent Address: _____

Phone Number: _____
Home__ Cell__
May I leave a message? Yes__ No__

Email Address: _____
May I contact you by email? Yes__ No__

Emergency Contact: _____
Phone Number: _____
Relationship: _____

Do I have permission to contact this person in case of emergency? Yes__ No__
If I have to contact this person, I will disclose information with caution.

Counseling Goals

What are the reasons for you seeking help at this time?

What are your goals for counseling?

Family Information

	Name(s)	Living?	Age(s)	Education	Major Illnesses, Addictions	Other Significant Issues
Father						
Mother						
Children						
Siblings						
Stepparents						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Spouse/Partner						
Other Significant People						

Physical and Mental Health History

Please list any *current* major health concerns:

Are you currently being treated by a medical professional? Yes__ No__
If yes, for what reason?

Please list all prescription medications you are currently taking, including how long you have been taking them and for which reason:

Prescribing professional: _____

Have you ever received counseling in the past? Yes__ No__
If yes, when and from whom?

What was helpful about the counseling process?

What was not helpful about the counseling process?

Have you ever had thoughts about suicide? Yes__ No__
If yes, when was the last time?

Have you ever seriously considered suicide? Yes__ No__
If yes, when was the last time?

Have you ever attempted suicide? Yes__ No__
If yes, when?

Have you ever intentionally injured yourself, without suicidal intent (e.g., by cutting or hitting yourself)?
Yes, currently__ Yes, in the past__ No__

Have you ever been hospitalized for a mental health reason? Yes__ No__
If yes, when, where, and for what reasons?

Have you ever intentionally physically harmed another person? Yes__ No__
If yes, whom and when?

Substance Use

Do you smoke? Yes__ No__
If yes, how much per day?

Do you regularly drink caffeine? Yes__ No__
If yes, how much per day?

Do regularly use alcohol? Yes__ No__
If yes, how many drinks per week?

Do you regularly use marijuana? Yes__ No__
If yes, how much per week?

Have you used any drug in the past month that was not prescribed by a doctor (such as cocaine, heroin, methamphetamine, ecstasy, LSD, pain pills, Ritalin, Adderall, Xanax, mushrooms)?
Yes__ No__

Have you or anyone in your life ever been concerned about your use of alcohol or other drugs?
Yes__ No__

Have you ever tried to stop or limit alcohol or other substance use, but could not? Yes__ No__

Please list any drug, alcohol, or other treatment programs you have been in:

Trauma/Loss

Please check if you have experienced any of the following types of trauma or loss:

__ Physical abuse	__ Homelessness	__ Neglect
__ Emotional abuse	__ Domestic violence	__ Loss of child
__ Sexual abuse	__ Parent or guardian substance abuse	__ Placing a child for adoption
__ Crime victim	__ Parent or guardian major illness	__ Teenage pregnancy

__Other (please list)

Current Functioning

Please check all of the symptoms and behaviors that are of concern for you:

__ Lack of life enjoyment
__ Lack of motivation
__ Crying spells
__ Fatigue
__ Persistent sadness
__ Hopelessness
__ Persistent guilt
__ Sense of worthlessness
__ Shame
__ Mood swings
__ Anxiety issues
__ Social anxiety
__ Overwhelmed with stress
__ Sleeping problems
__ Nightmares
__ Flashbacks
__Obsessive thoughts
__ Compulsive behavior
__ Difficulty concentrating
__ Feeling as if "driven by a motor"
__ Specific phobias (please specify)
__ Work/school problems
__ Addictions (please specify)
__ Eating problems
__ Problems with computer use
__ Problems with pornography
__ Gambling problems
__ Family conflict
__ Not feeling close to people
__ Isolation
__ Parenting problems
__ Intimate relationship problems
__ Anger outbursts
__ Physical aggression
__ Irritability
__ Feeling extremely energetic despite lack of sleep
__ Feeling detached from yourself
__ Suspiciousness or paranoia
__ Auditory hallucinations
__ Visual hallucinations
__ Cultural adjustment problems
__ Spiritual or religious issues
__ Death of a loved one
__ Other (please list)

What helps you cope during difficult times?

Work/School

Are you currently employed? Yes__ No__
If yes, please list your employer:

Current position:

Stress level at work: Low__ Medium__ High__

Are you currently in school? Yes__ No__
If yes, please list school, year in school, and major.

Stress level at school: Low__ Medium__ High__ Current GPA___

(CHILDREN ONLY) Please describe school functioning:

Other Information

Do you have a local social support network (family, friends, support groups, church, etc)?
Yes__ No__
If yes, please briefly describe:

What is your current living situation (e.g., living alone, with friends, roommates, family, partner/spouse, pets)?

Have you ever been convicted of a felony? Yes__ No__
If yes, when and for which reason?

How did you find out about my services?

If there is any other information you would like to provide, please include it below: