

# Integral Intake

To my client:

In my experience as a therapist, I've found that having clients' answers to the questions in this booklet is very helpful to the therapeutic process. It helps me know you more fully and know how to be more efficient and effective in helping you accomplish your goals in therapy. It can help you become more aware of aspects of your life related to your goals in therapy and help you clarify your thoughts and feelings related to your achievement of those goals through our work together. To help us make the most of our first sessions together, please complete this booklet and bring it with you to your first session with me. At that time, we can discuss any items that seem important to you or me for our work together to accomplish what you seek in therapy.

You may answer the questions very briefly, with just the main point, or in detail—whichever you prefer. Any answer you would like to discuss with me in more detail, put a mark, such as an asterisk (\*), to the left of the item. It may take you an hour or more to provide your answers; you may complete the booklet in one sitting or in two or more shorter sittings.

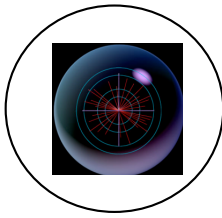
You may feel that some of your answers are very personal or too complicated to put in writing. If you prefer to discuss some answers rather than provide them in writing, just leave the lines blank and place an asterisk to the left of the item. However, please be assured that any answers you write, I will keep confidential to the extent that I'm able, as described in my Professional Disclosure Statement and my Privacy Policy.

Please contact me if you have any questions or concerns. I look forward to working with you.

Sincerely,

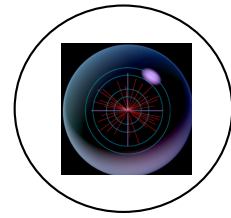
E. Scott Warren, PhD, LPC

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# WARREN COUNSELING SERVICES

## INTEGRAL INTAKE



Client's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ (message: Y/N) Work Phone: \_\_\_\_\_ (message: Y/N)  
Cell Phone: \_\_\_\_\_ (message: Y/N) Email: \_\_\_\_\_ (message: Y/N)  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: M F Referral Source: \_\_\_\_\_  
Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

(Please use additional pages if you need more space to respond to *any* of the questions)

### **PRELIMINARY ISSUES AND PREVIOUS THERAPY:**

What is the primary concern or problem for which you are seeking help?

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What makes it better? What makes it worse?

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Are there any ***immediate*** challenges or issues that need our attention? Yes/No If yes, please describe.

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Have you had previous counseling or psychotherapy? Yes/No From when to when? With whom?

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What was your experience of therapy? (What was your previous therapy like?)

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What was most helpful about your therapy?

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What was least helpful about your therapy?

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What did you learn about yourself through your previous therapy?

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What do you expect from our work together?

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**PERSONAL/OBJECTIVE:**

What are your strengths?

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What are your weaknesses?

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How would you describe your general mood/feelings?

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What emotions do you most often feel most strongly?

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What are the ways in which you care for and comfort your self when you feel distressed?

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How do you deal with strong emotions in yourself?

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How do you respond to stressful situations and other problems?

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How do you make decisions?

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Are you aware of recurring images or thoughts (either while awake or in dreams)? Yes/No

If yes, please describe.

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Have you ever attempted to seriously harm or kill yourself or anyone else? Yes/No If yes, please describe.

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Are you presently experiencing suicidal thoughts? Yes/No If yes, please describe.

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Has anyone in your family ever attempted or committed suicide? Yes/No If yes, please describe.

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Have there been any serious illnesses, births, deaths, or other losses or changes in your family within the last year? Yes/No If yes, please describe.

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What is your earliest memory?

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What is your happiest memory?

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What is your most painful memory?

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Where in your body do you feel stress?

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Do you have ways in which you express yourself creatively? Yes/No If yes, please describe.

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Describe your leisure time.

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Have you ever been a victim of, or witnessed, verbal, emotional, physical, and/or sexual abuse? If yes, please describe.

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In general, how satisfied are you with your life?

Not at all      1      2      3      4      5      6      7      Very

In general, how do you feel about yourself (self-esteem)?

Very bad      1      2      3      4      5      6      7      Very good

In general, how much control do you feel you have over your life and how you feel?

None at all      1      2      3      4      5      6      7      A lot

Please mark any of the following emotions that you often feel:

- ☐ angry
- ☐ sad
- ☐ lonely
- ☐ afraid
- ☐ anxious/worried
- ☐ shameful/guilty
- ☐ jealous
- ☐ happy
- ☐ grateful/thankful
- ☐ sexual/erotic
- ☐ excited
- ☐ energetic
- ☐ hopeful
- ☐ relaxed/peaceful
- ☐ other emotions you often feel: \_\_\_\_\_

**PERSONAL/OBJECTIVE:**

Please list any medications you are presently taking (dosage/amount and what the medication is for).

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Do you have a primary care physician? Yes/No. If yes, please provide their name and contact information:

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Height \_\_\_\_\_ Weight \_\_\_\_\_

When was your last physical? \_\_\_\_\_

Were there any noteworthy results or issues of concern (e.g., diseases, blood pressure, cholesterol, etc.)?

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Have you ever suffered a head injury or other serious injury? Yes/No If yes, please describe.

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What other significant medical problems have you experienced or are you experiencing now?

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Please mark any of the following behaviors or bodily feelings that are true of you:

- ☐ drink too much
- ☐ use illegal drugs
- ☐ eat too much
- ☐ eat too little
- ☐ neglect friends and family
- ☐ neglect self and your own needs
- ☐ difficulty being kind and loving to yourself
- ☐ act in ways that end up hurting yourself or others
- ☐ lose your temper
- ☐ seem to not have control over some behaviors
- ☐ think about suicide
- ☐ have difficulty concentrating
- ☐ spend more money than you can afford to
- ☐ crying
- ☐ headaches
- ☐ menstrual problems
- ☐ dizziness
- ☐ heart tremors
- ☐ jitters
- ☐ sexual pre-occupations
- ☐ tingling/numbness
- ☐ excessive tiredness
- ☐ hear or see things not actually there
- ☐ blackouts

Do you experience any other unusual behaviors or feelings? Yes/no. If yes, what are they?

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In general, how would you rate your physical health?

Very unhealthy   1            2            3            4            5            6            7            Very healthy

Describe your current sleeping patterns (When do you sleep? How many hours per 24 hrs? Do you sleep straight through or do you wake up during sleep time?). \_\_\_\_\_

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Do you feel rested upon waking?   Yes/No

Describe your normal eating habits (types of food and how much).

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Do you take vitamins and other nutritional supplements?   Yes/No   If yes please describe.

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Describe your drug and alcohol use (both past and present).

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Do you engage in some form of exercise?   Yes/No   If yes, please describe.

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Do you have any communication impairments?   Yes/No   If yes, please describe.

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**INTERPERSONAL/SYSTEM/SUBJECTIVE:**

Describe your relationships, including friends, family, and co-workers.

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What is important and meaningful to you (what matters the most to you)?

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In general, how satisfied are you with your friendships and other relationships?

Not at all      1      2      3      4      5      6      7      Very

In general, how comfortable are you in social situations?

Not at all      1      2      3      4      5      6      7      Very

Which emotions were encouraged or commonly expressed in your **family of origin** (the family you grew up with)?

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Which emotions were discouraged or not allowed in your **family of origin**?

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What emotions are most comfortable for you now?

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What emotions are most uncomfortable for you now?

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How do you identify yourself ethnically? How important is your ethnic culture to you?

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How did your *family of origin* express love and care?

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How does your *current family* express love and care?

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How did your *family of origin* express disapproval?

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How does your *current family* express disapproval?

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Describe your romantic/love relationships, if any.

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Describe your sex life. How satisfied are you with your sex life?

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What beliefs do you have about sex? How important to you are those beliefs?

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Do you have a religious/spiritual affiliation and/or practice? Yes/No Please explain.

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What beliefs do you have about religion/spirituality? How important to you are those beliefs?

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What are some of your most important morals? How important to you are those morals?

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What views/beliefs do you have about politics? How important to you are those views/beliefs?

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What views/beliefs do you have about the environment? How important to you are those views/beliefs?

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Do you participate in any volunteer work? Yes/No If yes, please describe.

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Are you involved with any cultural activities, organizations, or institutions? Yes/No If yes, please describe.

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**INTERPERSONAL/SYSTEM/OBJECTIVE:**

Describe your current *physical* home environment. For example, describe the layout of your home and other general conditions, such as privacy, lighting, décor, etc. Are you satisfied with it?

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Describe your current *social* home environment (how do you get along with those who live with you?)

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Describe your neighborhood. (Is it safe/dangerous, nice/unpleasant, quiet/loud, etc.?)

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Describe your work environment (include co-workers and supervisors who directly affect you).

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Do you have a spouse or romantic partner? Yes/No Have you been married before? Yes/No  
Please describe.

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Are you currently involved in a custody dispute? Yes/No If yes, please describe.

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What aspects of your life are stressful to you? Please describe.

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What sort of support system do you have (friends or family who help you in times of need)?

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What is your educational background?

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Not at all	1	2	3	4	5	6	7	Very
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Not at all	1	2	3	4	5	6	7	Very
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Name	Age	Gender	Relationship to you (include “step” and “half” etc.)
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[illegible]

Name	Age	Gender	Relationship to you (include “step” and “half” etc.)
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[illegible]

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