**Counseling Intake Form**

***Please answer all information as completely as possible. Information provided is strictly confidential.***

**Contact Information**

*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Home Address*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

*Home Phone*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Permission to call?* (circle one) Yes No *Leave message?* Yes No

*Work Phone:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Permission to call?* (circle one) Yes No *Leave message?* Yes No

*Cell Phone:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Permission to call?* (circle one) Yes No *Leave message?* Yes No *Text?* Yes No

*e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to e-mail for scheduling?* (circle one) Yes No

*Best time and method to contact you*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Name Relationship Phone

*Are you currently in counseling elsewhere?* (circle one) Yes No

*If yes, what type of counseling services are you currently receiving? (Check all that apply)*

Individual \_\_\_\_ Group \_\_\_\_ Marriage and Family \_\_\_\_ Couples \_\_\_\_

**Demographics**

*Date of Birth*\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_ *Age\_\_\_\_ SS#*\_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

*Race:*

African American\_\_\_ Bi-racial\_\_\_ Hispanic/Latina/Latino American\_\_\_Asian American\_\_\_ Caucasian\_\_\_

Native American\_\_\_ Other \_\_\_\_\_\_\_\_\_\_

*Ethnic Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Religion of origin:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion/Spirituality of Choice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Career/Lifestyle**

*Educational Level:*

8th grade or below \_\_\_\_\_\_\_ High School \_\_\_ GED \_\_\_ Trade School \_\_\_ Some College \_\_\_ College Graduate \_\_\_ Master’s Degree \_\_\_Ph. D. Degree \_\_\_\_

*Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Describe current vocation*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relational Information**

*Current living arrangements:*

Family of origin\_\_\_ Relatives\_\_\_ Single \_\_\_Married\_\_\_ Roommates(s)\_\_\_ Single parent w/children\_\_\_Married w/children\_\_\_ Significant other\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If living with a partner, how long?\_\_\_\_\_\_\_\_\_\_ Length of relationship:\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_*

*List members of your present family (partner, children, etc.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Gender | Relationship to you |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*List members of your family of origin (include step, half, etc.)*

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Gender | Relationship to you |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Physical Health**

*Primary Care Physician:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Name Address Phone

Date of most recent physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medical Concerns: (circle one) Yes No If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Disability: (circle one) Yes No If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Illness: (circle one) Yes No If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Terminal Illness: (circle one) Yes No If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health**

*Psychiatrist:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Name Address Phone

*Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)*? Yes No   
(If yes, I will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of Service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(beginning - ending)

*Check the following for any mental health diagnoses you have been given:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Diagnosis* | *Current* | *Past* | *Date of Diagnosis* | *Medication* | *Dosage* |
| ADHD/ADD |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Bipolar Disorder (Manic-Depression) *Circle:*  Bipolar I, Bipolar II, Cyclothymic Disorder |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Dissociative Disorder |  |  |  |  |  |
| Eating Disorder *Circle:*  Anorexia, Bulimia |  |  |  |  |  |
| Gender Identity Disorder |  |  |  |  |  |
| Impulse-Control Disorder *Circle:*  Anger, Kleptomania, Gambling, Pyromania, Trichotillomania |  |  |  |  |  |
| Obsessive-Compulsive Disorder (OCD) |  |  |  |  |  |
| Panic or Phobias |  |  |  |  |  |
| Personality Disorder *Circle:*  Paranoid, Schizoid, Schizotypal |  |  |  |  |  |
| Personality Disorder *Circle:*  Antisocial, Borderline, Histrionic, Narcissistic |  |  |  |  |  |
| Personality Disorder *Circle:*  Avoidant, Dependent, Obsessive-Compulsive |  |  |  |  |  |
| Process Addiction *Circle:*  Internet, Pornography, Relationship, Sex, Other: |  |  |  |  |  |
| PTSD |  |  |  |  |  |
| Sexual Disorder |  |  |  |  |  |
| Sleep Disorder (ex. Insomnia, Sleepwalking, etc.) |  |  |  |  |  |
| Substance-Related Disorder |  |  |  |  |  |
| Other: |  |  |  |  |  |

If you have been diagnosed, who gave the diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Name Type of provider Phone #

Have you ever been hospitalized for mental health concerns: (circle one) Yes No If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had thoughts of suicide? Current Past Never Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency, intensity, and duration of current suicidal thoughts:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide attempts? (circle one) Yes No If yes, when attempted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Means utilized?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospitalized: (circle one Yes No

List any other medications and dosages below:

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If you do not know the name or dosage of any medication, please bring it with you to your next appointment.)

What is the primary reason you are seeking counseling at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark up to 10 items below using a significance rating of 1-mildly significant; 2-somewhat significant; 3-very significant. Put an asterisk next to the most significant item at this time.

\_\_Abuse (physical, emotional, sexual)

\_\_Adjustment to life changes (moving, marriage, divorce, aging, etc.)

\_\_Career dissatisfaction or decisions

\_\_Disturbing memories (past abuse, neglect or other traumatic experience)

\_\_Drug or alcohol use

\_\_Eating problem (binging, purging, overeating, hoarding, severely restricting diet)

\_\_Family or Step-family relationship

\_\_Feeling angry or irritable

\_\_Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)

\_\_Feeling guilty or shameful

\_\_Feeling sadness or depression or suicidal urges

\_\_Grief and loss

\_\_Health concerns

\_\_Non-family relationship (roommates, friends, co-worker, boss, etc.)

\_\_Parent-Child relationship (discipline, adoption, single parent, etc.)

\_\_Personal Growth (no specific problem)

\_\_Religious or Spiritual concerns

\_\_Sexual functioning concerns

\_\_Sexual identity concern

\_\_Significant other/spouse relationship

\_\_Sleep problems (nightmares, sleeping too much or too little, etc.)

\_\_Unusual behavior (bizarre actions, speech, compulsive behavior, tics, etc.)

\_\_Unusual experiences (loss of periods of time, seeing unreal things, etc.)

\_\_Other (explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

When did you first become concerned about this issue?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have you attempted to deal with this issue before?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other treatment you have received to address any of the concerns indicated above: None\_\_\_

Couples counseling \_\_\_\_ Group counseling \_\_\_\_\_ Individual counseling \_\_\_\_

Family counseling \_\_\_\_ Hospitalization \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What else would you like me to know?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Indicate the type, frequency, and amount of use of the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Substance** | **Type** | **Frequency** | **Amount** |
| Alcohol |  |  |  |
| Drugs |  |  |  |
| Nicotine |  |  |  |
| Caffeine |  |  |  |

**Family History**

*Raised by:*

|  |  |  |
| --- | --- | --- |
| Adoptive parent(s)\_\_ | Institution\_\_ | Relatives\_\_ |
| Foster parent(s)\_\_ | Natural parents\_\_ | Single natural parent\_\_ |
| Grandparent(s)\_\_ | Natural and step-parent\_\_ | Other\_\_ |

*Stressors in the family (indicate approximate age at the time stressor occurred):*

Chronic illness of family member:\_\_\_\_\_ Death of significant person(s):\_\_\_\_ Domestic Violence:\_\_\_\_\_\_

Family member absent (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member’s disability/major accident/illness: \_\_\_\_ Financial problems: \_\_\_\_ Frequent moves: \_\_\_\_\_\_

Family member emotional problems (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family member suicide (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*History of learning, emotional, behavioral problems:* (circle one) Yes No  
If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*History of alcohol/drug/substance abuse:* (circle one) Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*History of family violence:* (circle one)Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*History of criminal activity:* (circle one)Yes No

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*History of abuse* (check all that apply): Physical \_\_\_ Emotional \_\_\_ Sexual \_\_\_  
*History of neglect* (check all that apply): Physical \_\_\_ Emotional \_\_\_

*School Problems* (check all that apply): Academic problems\_\_\_ Discipline problems\_\_\_Severely teased/bullied\_\_\_\_  
Unpopular\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Emotional Concerns* (check all that apply):

|  |  |  |
| --- | --- | --- |
| Appetite change\_\_ | Heard voices\_\_ | Suicidal thoughts\_\_ |
| Emotional problems\_\_ | Loss of energy of fatigue\_\_ | Suicide attempts\_\_ |
| Gained weight\_\_ | Lost weight\_\_ | Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Behavioral Problems* (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| Accident-prone\_\_ | Aggressive behavior (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Alcohol/Drug use\_\_ | Attention problems\_\_ | Frequent arguments\_\_ | Hyperactive\_\_ |
| Impulsive\_\_ | Loner\_\_ | Misbehaved a lot\_\_ | Ran away\_\_ |
| Self-abuse (burning, cutting, etc.)\_\_\_\_ | | Taken advantage of\_\_ | Temper outbursts\_\_ |
| Trouble with the law\_\_ | Other\_\_\_\_\_\_\_\_\_\_\_ |  |  |

*Anxiety Symptoms* (check all that apply):

|  |  |  |
| --- | --- | --- |
| Irritable\_\_ | Obsessive worrying\_\_ | Physical symptoms (below)\_\_ |
| Keyed up/on edge\_\_ | Phobias | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Health/Physical Problems* (check all that apply):

|  |  |  |
| --- | --- | --- |
| Asthma\_\_ | Disability\_\_ | Nervous stomach\_\_ |
| Bedwetting\_\_ | Dizziness\_\_ | Neurological problems/exam\_\_ |
| Bone/joint/muscle\_\_ | Headaches\_\_ | PMS\_\_ |
| Chest pain\_\_ | Heart palpitations\_\_ | Serious overeating/undereating\_\_ |
| Chronic illness\_\_ | Hospitalization\_\_ | Shortness of breath w/o exertion\_\_ |
| Developmental delay(s)\_\_ | Major accident\_\_ | Sleep problems\_\_ |
| Diarrhea\_\_ | Major illness\_\_ | Surgeries\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Dissociative Symptoms* (check all that apply):

|  |  |
| --- | --- |
| Amnesia of large parts of childhood after age 5\_\_\_ | Things of yours that are missing\_\_\_ |
| Memories suddenly flashback\_\_\_ | Trance-like episodes/losing time\_\_\_ |
| Things appear, but you don’t know origin\_\_\_ | Walking in sleep\_\_\_ |

*Trauma/Stressor* (check all that apply):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bullied\_\_\_ | Child separated from parent (how long & when)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Death of a pet\_\_\_ | | Death of a significant person\_\_\_\_ | | Incarcerated family member\_\_\_\_ |
| Medical\_\_\_ | | Natural disaster\_\_\_ | | Sexual assault\_\_\_\_ |
| Victim of trauma (unusual, terrifying experience)\_\_\_\_ | | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

*Specific to Adulthood* (check all that apply):

|  |  |  |
| --- | --- | --- |
| Abortion\_\_\_\_ | Sexual problems (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Major life change(s) in past year\_\_\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Parenting/Discipline problems\_\_\_ | | Placing child for adoption\_\_\_\_ |

**Support System**

From whom can you get support when you need it (friends, relatives, school, church, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate the level of support you feel you can obtain when needed?

Little support 1-----2-----3-----4-----5 Great deal of support