

Wendy Bruton, M.A., LLC

Counselor/Therapist

Oak Springs Counseling and Evaluation

838 Commercial St. NE Salem, OR 97301

Phone: 503.910.5880 Fax: 503.363.0068 Email: wendy@wendybruton.com

www.wendybruton.com

Individual Intake

Name _____ Age _____ Birth date _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

Religion _____ Church affiliation _____

If client is a minor, Name of responsible adult _____

Name of closest friend/relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

Some of these questions may not apply to you. Please feel free to write N/A on questions that are not applicable to your situation. We will go through this form during our first session. If you are unsure how to answer a question, we can discuss it during our time together.

Do you smoke? _____ How much? _____

When was the last time you drank alcohol? _____ How much? _____

When was the last time you used drugs? _____ What kind? _____

Date of your last medical examination _____ Reason _____

Are you now under a doctor's care? _____ If yes, doctor's name: _____

Reason for doctor's care: _____

Are you taking any medication? _____ If yes, what kind? _____

Have you been hospitalized for a physical illness within the past 6 months? _____ Describe: _____

Have you ever been hospitalized for a mental illness, personality disorder, anxiety, depression, etc? Describe:

Any previous therapy/counseling? _____ If yes, name and phone numbers of therapists: _____

How were you referred to me: _____

Please describe the main difficulty that has brought you to see me: _____

What solutions or efforts have you tried to solve the problems that bring you here? _____

What do you want to achieve through Therapy? _____

More about YOU!:

List five things you like about yourself: _____

List five things about yourself you would like to change: _____

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

List any major problems or stressful events that other family members or close friends are currently dealing with:

Check Any of the Following That May Apply to You:

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	Shy With People
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Feel Tense	<input type="checkbox"/>	Can't Make Friends
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Feel Panicky	<input type="checkbox"/>	Afraid Of People
<input type="checkbox"/>	No Appetite	<input type="checkbox"/>	Fears and Phobias	<input type="checkbox"/>	Home Conditions Bad
<input type="checkbox"/>	Over-Eating	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	Unable To Have A Good Time
<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Always Worried About Something
<input type="checkbox"/>	Bowel Disturbances	<input type="checkbox"/>	Suicidal Ideas	<input type="checkbox"/>	Don't Like Weekends/Vacations
<input type="checkbox"/>	Always Tired	<input type="checkbox"/>	Take Tranquilizers	<input type="checkbox"/>	Can't Make Decisions
<input type="checkbox"/>	Always Sleepy	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Over-Ambitious
<input type="checkbox"/>	Unable To Relax	<input type="checkbox"/>	Dangerous Drugs	<input type="checkbox"/>	Financial Problems
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	Recurrent Dreams	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Job Problems
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Homosexuality	<input type="checkbox"/>	Can't Keep A Job
<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	Other

Relationships in your family of origin. Please describe the following (you may use addition paper):

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

Present relationships:

How do you get along with your present spouse or partner? _____

How do you get along with your children? _____

Trauma:

What two events in your life do you perceive as being the most traumatic events you have lived through? _____

Abuse history: _____ I was not abused in any way _____ I was abused. If you were abused, please indicate the following:

For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect. E = Emotional, such as humiliation

Your Age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Chemical Use History:

Have you ever felt the need to cut down on your drinking? _____ No _____ Yes

Have you ever felt annoyed by criticism of your drinking? _____ No _____ Yes

Have you ever felt guilty about your drinking? _____ No _____ Yes

Have you ever taken a morning "eye opener"? _____ No _____ Yes

How much beer, wine, or hard liquor do you consume each week, on average? _____

Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____

How much tobacco do you smoke or chew each week? _____

Which drugs (not medications used as they were perscribed for you) have you used in the past 10 years? _____

Legal History:

Are you presently involved in a law suit? If yes, please explain. _____

Are you required by a court to have this appointment? If yes, please explain _____

Are there other legal involvements I should know about? _____

Other:

Is there anything else that is important for me as your therapist to know about? If yes, please tell me about it here or on another sheet of paper: _____

Thank you so much for taking the time to answer these questions. Please sign below indicating that all of the information provided above is true and complete to the best of your knowledge.

Client's Signature

Date