CHRISTIAN COUNSELING ASSOCIATES

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COMPREHENSIVE ADULT PSYCHOSOCIAL/TREATMENT PLAN
CONFIDENTIAL

NAME_____ EMERGENCY CONTACT_____

PHONE_____

CURRENT LIVING SITUATION

Describe your living arrangements (*check all that apply*)

____living with spouse/partner ____living with biological family ____living alone ____living with relatives

____adoptive family ____living with friends ____foster family ____own/rent private residence

____residential care home ____institutional setting ____community shelter or homeless

Children Living at home:

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Children Living Outside of Home:

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

___Yes ___No Do you have problems with your children? Describe_____

_____

Please list other individuals living in your home with you, including any who visit regularly

Name	Age	Relationship to you

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you?_____

Please write a couple of sentences concerning the reason for your request of services.

_____

_____

_____

Describe Your Partner (check all that apply)

____warm ____abusive ____tense ____unhappy ____critical ____distant ____perfect

____affectionate ____boring ____caring ____dependent ____happy ____indifferent ____violent

____alcohol/drug/dependent behavioral addiction_____

other_____

Is There Violence In The Home? ____No ____Yes

Type: ____mental ____physical ____emotional or verbal ____spiritual

Do you have any of the following problems with your partner?

____difficulty w/or conflict over sex ____jealousy ____abuse ____affairs ____conflict over employment

____conflict over children ____conflict over money ____conflict over power

____conflict over substance or behavioral addictions ____relationship w/partner is satisfactory

____have no current partner

If so, are you concerned about lacking a significant relationship ____Yes ____No

Additional comments_____

Ethnic Group ____Caucasian ____Black ____Alaskan Native ____Asian/Pacific Islander

____American Indian, tribe_____ ____Hispanic_____ ____Other_____

Cultural Information *check all descriptions that apply regarding who or what life events have had the most influence on you*

____holidays ____chaotic family ____violence ____trauma ____disabilities ____addictions

____spirituality/religion ____family traditions ____family culture ____friends ____neighbors ____abuse

____learning/education ____school ____sports ____work ____social ____scouting

____lifestyle choices ____travel ____reading ____gender ____social status ____foods

____nontraditional roles or experiences ____community organizations

____other *describe*_____

Note the relationship(s) of those people who were instrumental in influencing your life either positively (+) or negatively (-) (mother, father, sibling, grandparent, aunt/uncle, stepparent, cousin, friend, etc.)_____

_____

Check the problems for which you are seeking help *check all that apply*

____crisis ____trauma ____child's behavior ____school ____family issue ____work ____isolated

____anger ____stress ____medical ____grief/loss ____conflict ____DHS ____divorce ____step family

____court ____DUI ____EAP referral ____parenting ____impulsive behaviors ____bullying ____marital

____ sibling issues ____abuse ____parent/child ____communication ____social skills ____boundaries

____problem solving skills ____difficulty making/keeping friends ____pre-marital ____sexual conflict/guilt

____problems w/sexual partner ____overwhelming emotions ____sexual identity conflict ____rape/sexual assault

____other *describe*_____

Describe how long this has been a problem_____

Tell how you have already tried to solve the problem_____

	Low									High
How serious is this problem for you? (*please circle)*	1	2	3	4	5	6	7	8	9	10
How hopeful are you that your life can be better?	1	2	3	4	5	6	7	8	9	10

Describe how you want your life to be different as a result of counseling_____

_____

How long do you think it will take to resolve the problem(s) ____1-3 visits ____2-3 months ____6 months ____other

Additional comments: Please include significant losses or events in your life (including experiences with pets).

_____

_____

Describe your strengths or the things you do well _____

_____

What or who do you rely on for help or name the important relationships in your life:

____faith ____family ____friends ____co-workers ____neighbors ____other

*describe*_____

Describe what you do for recreation or fun/leisure (include the type of activity and the frequency)

_____

Affect/Mood—Describe your experience (*check all that apply*)

____mood swings ____depression ____grief ____anger ____numbness ____sadness ____anxiety/anxiousness

____low energy ____don't care about anything ____euphoria ____overwhelmed ____unable to cope with emotions

____change in appetite/sleep patterns ____thoughts of hurting myself or someone else

Additional comments_____

Thinking/Mental Process—Describe your experience (*check all that apply*)

____oriented to person, time, place ____memory problems (___short term ___long term) ____impulse control

____ideas of guilt ____difficulty concentrating ____obsessive behaviors ____disturbing nightmares/dreams

____difficulty making decisions ____dissatisfied with decisions made ____feel persecuted/picked on

____feelings of being unreal ____suspicious of people/low trust ____negative beliefs about yourself

____ideas of hopelessness ____ideas of worthlessness ____preoccupied with sex ____ideas of loss (hopes/dreams)

____other people cause my problems ____can't shut down thoughts ____follow my faith even when it causes problems

Delusions/hallucination ____auditory ____visual ____delusions_____

Additional comments_____

Educational/Occupational/History

____Yes ____No Are you the primary person responsible for home management?

Attitude toward school: ____liked it ____indifferent ____disliked it

Grades were primarily_____ If in school now, where?_____

____Yes ____No Have you ever served in the military?

____Yes ____No Experienced war?

____Yes ____No Do you have a service connected disability? Describe_____

How do you support yourself? ____employment ____social security ____disability ____government assistance

____help from others ____other_____

What is your feeling/attitude towards your job? ____like it ____indifferent ____dislike it

____Yes ____No Problems on the job? Explain_____

____Yes ____No Have you ever been fired/laid off?

____Yes ____No Medical reason you cannot work?

Describe:_____

Do you consider yourself ____effective ____impaired ____ineffective in the roles identified above?

Personal History

Describe any physical or emotional problems, of which you are aware, during your childhood:_____

_____

Your primary caregivers during childhood were: ____birth parents ____mother only ____father only

____father & stepmother ____mother & stepfather ____adoptive parents ____foster parents ____grandparents

other_____

Place/location of birth_____

Names/ages of siblings_____

____Yes ____No Do you have any difficulty remembering or describing your childhood?

____Yes ____No Did your parents argue frequently?

____Yes ____No If yes, was any physical violence involved?

____Yes ____No Are your parents divorced?

____Yes ____No Were you physically abused? If Yes, by whom?_____

____Yes ____No Did the family in which you grew up experience severe financial problems?

____Yes ____No Has any inappropriate sexual behavior ever taken place around you or directed toward you?

If yes, by whom?_____(*name & relationship*) Your age_____

Additional Comments_____

Describe yourself as a child (C) or adolescent (A): *check all that apply*

C___ A___ Outgoing	C___ A___ Rebellious	C___ A___ Popular	C___ A___ Awkward
C___ A___ Unhappy	C___ A___ Quiet	C___ A___ Serious	C___ A___ Happy
C___ A___ Aggressive	C___ A___ Temperamental	C___ A___ Calm	C___ A___ Unpopular
C___ A___ Nervous	C___ A___ Angry	C___ A___ Thoughts of Suicide	

Other_____ Things changed when I reached age _____

Because_____

Check the following you experienced as a child (C) and/or adolescent (A): *check all that apply*

C___ A___ conflict w/mother	C___ A___ conflict w/father	C___ A___ conflict w/siblings
C___ A___ conflict w/stepmother	C___ A___ conflict w/stepfather	C___ A___ conflict w/peers
C___ A___ targeted by bully	C___ A___ conflict w/teachers	C___ A___ conflict w/police
C___ A___ conflict w/neighbors	C___ A___ conflict w/stepsiblings	C___ A___ overweight
C___ A___ anorexic/bulimic	C___ A___ nightmares	C___ A___ excessive fear/worry
C___ A___ drug/alcohol use	C___ A___ bedwetting	C___ A___ fire starting
C___ A___ arrests/delinquency	C___ A___ cruelty to animals	C___ A___ attempted suicide
C___ A___ sexual problems	C___ A___ teen parent	

Other_____

Describe your caregivers: **mother (M), father (F), stepmother (SM), Stepfather (SF), Other Caregiver (OC)**

(*check all that apply)*

	M	F	SM	SF	OC		M	F	SM	SF	OC
Warm	___	___	___	___	___	Overprotective	___	___	___	___	___
Domineering	___	___	___	___	___	Affectionate	___	___	___	___	___
Uncaring	___	___	___	___	___	Fault-Finding	___	___	___	___	___
Average	___	___	___	___	___	Strict	___	___	___	___	___
Smothering	___	___	___	___	___	Absent	___	___	___	___	___
Understanding	___	___	___	___	___	Rejecting	___	___	___	___	___
Distant	___	___	___	___	___	Perfect	___	___	___	___	___
Supportive	___	___	___	___	___	Too Little Discipline	___	___	___	___	___
Alcohol/Drug Use	___	___	___	___	___	Behavioral Addiction	___	___	___	___	___
Depressed/Unhappy	___	___	___	___	___						

Legal Issues

Do you have any legal issues pending? ___Yes ___No	Are you on probation or parole? ___Yes ___No
Do you have a legal/criminal record? ___Yes ___No	Ever been arrested as an adult? ___Yes ___No
Have you ever been incarcerated? ___Yes ___No	Any current DHS/Court involvement? ___Yes ___No

If yes to any of the above, please describe_____

Conflict/Violence/Trauma Issues

Ever been threatened/attacked/afraid for safety/life? ___Yes ___No

Experienced intimidation/control? ___Yes ___No

Grew up in a home with chronic problems? ___Yes ___No

Been a target of gender violence? ___Yes ___No

Been a target of racism/discrimination? ___Yes ___No

Been a target of bully at school or work? ___Yes ___No

Additional Comments_____

Substance/Behavioral Addiction History

___Yes ___No My family has a history of addictions

If yes, who? ___grandfather ___grandmother ___father ___mother ___sibling ___other relatives

___Yes ___No I am concerned about my partner's use of substances/behaviors

___Yes ___No I am concerned about my child's use of substances/behaviors

Please indicate the impact addictions have on your life, relationships, work, etc._____

I have a history of using/abusing the following:

Substance or Behavior	What and/or how Much	Age of 1st use	Age of last use or still using	Oral, nasal, smoking, injection, other	Treatment or 12 step or group
Alcohol					
Drugs					
Prescription meds					
Tobacco					
Caffeine, teas, sodas					
Gambling					
Excessive Computer use					
*Sex					
**Codependency					
***Food issues					

**Sex includes pornography, several partners, etc.*
***Codependency (focusing on others' behaviors, generally putting others first, feeling used & taken for granted*
****Food includes excessive sugar, salt, junk foods, overweight, anorexia, bulimia*

MEDICAL

___Yes ___No Are you **currently** under the care of a physician for medical problems? (*your physician will not be contacted without your permission)*

If yes, describe:_____

_____

Physician Name:_____ Phone:_____

Address:_____ City, State, Zip_____

___Yes ___ No Are you **currently** taking medications?

If yes, list those you are **currently** taking (use back of page if needed).

Medication	Strength/Dosage	Length Taken	Purpose & Side Effects

Please list any allergies:_____

In your opinion what is your current level of health? ___excellent ___good ___fair ___poor

In your opinion are you ___underweight ___appropriate weight ___overweight how many pounds_____

Do you now or have you ever had:

___Yes ___No Hearing problems

___Yes ___No Unable to move part of your body

___Yes ___No Pains in your chest

___Yes ___No Hands, feet, ankle swelling

___Yes ___No Kidney trouble

___Yes ___No Decreased interest in sex

___Yes ___No Constipation/diarrhea

___Yes ___No Eye problems

___Yes ___No Surgeries Dates/Types:_____

___Yes ___No Severe headaches

___Yes ___No Goiter, thyroid problem

___Yes ___No Abnormal thirst or hunger

___Yes ___No Stomach trouble, ulcers

___Yes ___No Sleeping problems

___Yes ___No Liver disease, yellow skin/eyes

___Yes ___No Fainting spells/falling/dizzy

___Yes ___No Change in appetite

Check any that apply to you now or in the past:

___ measles	___polio	___German measles	___meningitis	___mumps
___ diphtheria	___lupus	___ high blood pressure	___pneumonia	___glaucoma
___ rheumatic fever	___skin problems	___thyroid disease	___diabetes	___heart problems
___ bleeding ulcers	___mononucleosis	___blood clots	___anemia	___epilepsy/seizures
___ food poisoning	___hepatitis	___HIV positive	___frequent colds	___broken bones
___ concussions	___dislocations	___wounds	___head injury	___cancer
___ fatigue	___weakness	___chills	___night sweats	

___ sexually transmitted disease ___enlarged prostate ___impotence ___menstrual problems

___ still having period ___age at first period ___hormone replacement ___mood difficulty during menstrual cycle

Pregnancy history: Total # of pregnancies ____ # of premature births ____ # of C-sections ____

# of stillbirths ____ # of miscarriages ____ # of surgical abortions ____

Does anyone in your family experience:

___ depression ___bipolar ___schizophrenia **If yes, who?** ___ mother ___father ___sibling

___Yes ___No Are you **currently** receiving behavioral/mental health services elsewhere?

If yes, please provide the following:

Date	Type*	Where	Purpose/Diagnosis

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

___Yes ___No Have you received behavioral/mental health services in the past?

If yes, provide the following (use back of page if needed).

Date	Type*	Where	Purpose/Diagnosis

How many self-help meetings have you attended in the past 30 days?_____

Please include any other information you feel is important for the therapist to know.

_____

_____

SPIRITUAL

Personal Religious Information:

___Yes ___No My spiritual beliefs are a significant factor in my life.

___Yes ___No I am involved in church/religion/spiritual practice. My church home is_____

I attend (*circle*) Several times week Weekly Monthly Sporadically Seldom Never

My spouse attends (*circle*) Several times week Weekly Monthly Sporadically Seldom Never

My religious background is _____ My spouse's religious background is_____

Describe any significant religious experiences:_____

_____

Describe any unexplainable experiences:_____

_____

___Yes ___No I have made the discovery of knowing Jesus Christ personally.

Describe your experience:_____

_____

___Yes ___No I am satisfied with my personal faith.

Additional Comments:_____

_____

X_____

Client Signature Date

X_____

Signature of Staff Person Completing Intake Date