

**Jesse Whittle-Utter, M.A.,
Licensed Marriage & Family Therapist #79783
INDIVIDUAL INTAKE FORM - CONFIDENTIAL**

Date:

For the following questions, feel free to answer in as much or as little detail as you wish. Your responses will be used as a starting point for further discussion in our work as we explore your presenting issue(s). You may use additional paper if you like.

Background Information

1. In your own words, describe the reason(s) why you are seeking therapy at this time.

2. Please check-off any of the following that you can relate to or are of a current concern.

Physical:

- | | | |
|--|--|--|
| <input type="checkbox"/> Often tired | <input type="checkbox"/> Over-eating | <input type="checkbox"/> Chronic pain or illness |
| <input type="checkbox"/> Over-sleeping | <input type="checkbox"/> Under-eating | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Under-sleeping | <input type="checkbox"/> No appetite | <input type="checkbox"/> Reliance on alcohol |
| <input type="checkbox"/> Nightmares or terrors | <input type="checkbox"/> Body image concerns | <input type="checkbox"/> Reliance on drugs |

Mental and Emotional:

- | | | |
|--|--|---|
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Feelings of guilt or shame |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Anger or irritation | <input type="checkbox"/> Unusual thoughts |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Emotion expression | <input type="checkbox"/> Obsessions or compulsions |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Feelings of panic | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Often worried | <input type="checkbox"/> Feelings of worthlessness | |

Occupational and social:

- | | | |
|---|---|---|
| <input type="checkbox"/> Work or career | <input type="checkbox"/> Overly ambitious | <input type="checkbox"/> Difficulty making friends |
| <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Often afraid of people | <input type="checkbox"/> Difficulty keeping friends |
| <input type="checkbox"/> Education | <input type="checkbox"/> Often avoiding people | <input type="checkbox"/> Difficulty having fun |

Family and Relationships:

- | | | |
|---|--|--|
| <input type="checkbox"/> Current family conflicts | <input type="checkbox"/> Parenting or children | <input type="checkbox"/> Intimacy concerns |
| <input type="checkbox"/> Past family conflicts | <input type="checkbox"/> Relationship concerns | |

Identity:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sexual orientation | <input type="checkbox"/> <input type="checkbox"/> Coming out | <input type="checkbox"/> <input type="checkbox"/> Cultural |
| <input type="checkbox"/> Gender | <input type="checkbox"/> <input type="checkbox"/> Alternative lifestyle | <input type="checkbox"/> <input type="checkbox"/> Religious/Spiritual |

**Jesse Whittle-Utter, M.A.,
Licensed Marriage & Family Therapist #79783**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? If yes, when and for what reason(s)?

If you answered "Yes" to the above, please describe what you found particularly helpful or unhelpful about your experience(s), and why:

Have you ever made suicidal gestures or attempts? If so, please describe and include when, how you made the attempt, and what your feelings were at the time.

Have you ever physically harmed, or have ever seriously considered physically harming, someone? If so, please describe and include when, how you made the attempt, and what your feelings were at the time.

Is anyone currently hitting, hurting, belittling, demeaning, pressuring, or touching you in an unwanted or abusive manner? Has anyone in the past?

Please describe your household composition (who lives with you, their ages & relationship to you).

Please share any significant medical history, including information about past and current medical problems, allergies, major operations, and list any current medications (type, amount, frequency, and duration) and any general health concerns (invisible/chronic disabilities or illnesses). Please also include the date of your last physical exam.

**Jesse Whittle-Utter, M.A.,
Licensed Marriage & Family Therapist #79783**

Do you drink alcohol or use any substances? If yes, what kind, how much, and what kind of effect does it have on you physically and mentally?

Family and Personal History

What did your family structure look like growing up (e.g. parents, siblings, extended family involved, who was involved in raising you, etc.)?

How did these family members relate to you growing up? If different, how do they relate to you now as an adult?

Did you experience any separations, divorces, deaths, or other major experiences growing up? What were the circumstances and how did you experience them?

Is there any history of abuse (emotional, physical, and/or sexual) in your family?

Is there any history of mental illness or drug/alcohol abuse in your family? If yes, please describe.

What is your educational and work history, including current place of employment (if any)?

**Jesse Whittle-Utter, M.A.,
Licensed Marriage & Family Therapist #79783**

Please describe any significant social or community contacts in your life. To what extent are you involved in/supported by a larger community—such as group involvement, political activity, community events, social events, professional associations, religious/spiritual affiliations, etc.?

Please describe your relationship history & current relationships (past and present significant relationships with lovers, spouses, friends, children, and peers. Note degree of satisfaction and any problems/dysfunction.)

Self-Care Strategies and Support

What coping strategies do you use to deal with stress? Has anyone ever expressed concern about, or are you concerned about, any of these strategies and potential for self-destructive behaviors?

What does your current support system look like (e.g. family members, friends, support groups, pets, etc.)?

Do you have a spiritual practice or religious affiliation that is important to you? If so, please elaborate.

What do you consider some of your strengths are as an individual?

Is there anything else you would like to add that was not asked on this form?

How did you hear about my services?