

Maureen A. Malcolm, M.A., LPC
INTAKE FORM

Name: _____ Date: / /

1. What is the overarching problem or situation that brought you here?

2. How does the problem affect you?

3. Check the box of all you have experienced:

- | | | |
|--|---|---|
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Suicide Attempt, Threat | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Alcohol and/or Drug Use | <input type="checkbox"/> Family/Relationship Conflict | <input type="checkbox"/> Worry/Anxiety |
| <input type="checkbox"/> Verbal Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Psychological Abuse | <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Learning Difference | <input type="checkbox"/> Grief and/or Loss | <input type="checkbox"/> Discrimination |

Please describe each of the above issues with which you identify?

Other Problems:

4. Who else in your life knows about and/or is affected by these problems?

5. What goals would you like to achieve by coming to counseling?

6. What *ideas* do you have for how these goals may be accomplished?

7. What values, purposes, hopes, beliefs, intentions or commitments motivate you towards reaching your goals?

8. What type of learning do you gravitate towards, *auditory* (learn by hearing), *visual* (learn by seeing, watching), or *kinesthetic* (learn by doing)?

9. Is there anything else you would like me to know?
