



- Gathered Connections Counseling

## BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION - ADULT

### Demographic Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Gender: \_\_\_\_\_

Sexuality: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

*Is it ok to leave a voicemail?* YES NO

Email: \_\_\_\_\_

*Would you like to receive email communication?* YES NO

*Is it ok to send something in the mail?* YES NO

How were you introduced to us? \_\_\_\_\_

**Gathered Connections Counseling, PLLC 623-201-0719**

[info@gatheredconnectionsounseling.com](mailto:info@gatheredconnectionsounseling.com)

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**Goodyear, AZ 85395**

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*\* Please complete below for additional client*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Gender: \_\_\_\_\_

Sexuality: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

*Is it ok to leave a voicemail?* YES NO

Email: \_\_\_\_\_

*Would you like to receive email communication?* YES NO

### **How Have We Come to Meet?**

What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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What solutions (helpful or unhelpful) have you tried to resolve your concerns?

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Have you had therapy in the past? If so, with whom and when? What reasons did you attend therapy for? Please share with us about your experience. What was helpful? unhelpful?

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### **Change is Coming...**

What are your expectations from therapy? What are your expectations of the therapist?

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What other things would you like to see change in your life (family, career, health, relationships, etc.)?

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Do you foresee any obstacles to achieving your goals or the desired changes?

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List 5 strengths about yourself or that others say about you, give examples of each:

1. 

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2. 

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3. 

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4. 

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5. 

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Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

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## Medical & Mental Health Information

Have you ever received psychiatric services before?

YES

NO

If yes, how long ago, with whom, for what, medications prescribed and results:

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List any medications (over-the-counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

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## Important Questions We Must Ask

Have you ever had thoughts of killing yourself? YES NO

If yes, please explain:

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Have you ever planned on killing yourself? YES NO

If yes, please explain:

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Have you ever attempted to kill yourself? YES NO

If yes, please explain:

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Has anyone in your family or close to you died by suicide? YES NO

If yes, please explain:

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Have you ever felt you wanted to seriously harm or kill someone else?      YES      NO

If yes, please explain:

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Do you have weapons in your home or access to weapons?      YES      NO

If yes, who has access to them and what are the safety protocols around them?

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Is there any history or presence of abuse or violence?      YES      NO

If so, please explain:

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Are you currently using any illegal drugs or prescription medications in a way other than was prescribed, or is the reason you are seeking therapy services substance related?

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Have you ever witnessed or experienced a trauma? Do you have recurring nightmares, flashbacks, or do you avoid anything that is uncomfortable or painful? If so, please explain:

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Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

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### **Career/Job, Recreation and Hobbies**

What is your current occupation? How would you describe your fulfillment of your job/career?

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What is your highest level of education completed and field of study?

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What do you enjoy doing during your free time?

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## Intimate Relationships

If you are currently in a relationship, describe your relationship:

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How would you describe your communication?

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Significant Other/Spouse:

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Children:

1. Child 1

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2. Child 2

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3. Child 3

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## Understanding Your Family & Influences

*\* Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married      Divorced      Never Married      Separated      Domestic Partners  
Widowed

Please describe your relationship with your parents:

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How would you describe your upbringing?

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Who lives with you currently?

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Do you have any pets? If yes, names, types and relationship to each pet:

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Describe your relationship with the following:

Mother:

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Father:

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Mother's Significant Other:

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Father's Significant Other:

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Siblings: Age, Name and Sex:

1. Sibling 1

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2. Sibling 2

---

3. Sibling 3

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## Relationships

Describe your relationship with your friends:

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Who would you say your support system is (people, organizations, or affiliations)?

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Do you belong to any religious or spiritual groups?

YES

NO

If yes, what is your level of involvement?

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How do your religious or spiritual beliefs/practices influence your life?

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Please list anything else that is important for us to know about you that would assist us in working with you to achieve your desired results:

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