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PSYCHOTHERAPY INDIVIDUAL INTEGRAL INTAKE

Introduction

This comprehensive Integral Intake Form addresses many different aspects of your life. It helps me gather important information about your past and present right from the beginning of our work together, which otherwise could take us some time to get to. Ultimately, it supports me in helping you best.

In most likelihood, not all questions will apply to you. Also, please only answer the questions you feel comfortable answering at this early stage of our work. **If you feel that some of these questions are too personal to share with me at this early stage, too emotionally charged, too complicated to put in writing, or you simply prefer not to answer them at this time, please respect your limits and comfort level**. **Should you prefer not to answer most of them, know that completing the first two pages will fulfill my legal and ethical obligations, and that it is your absolute right to do so.** If some of these questions are of particular importance to you –even questions you may choose not to answer at this time but may want to come back to eventually– just put an asterisk [*] to the left of the questions. The overall form might bring up memories that you may have forgotten, or discounted as irrelevant. It might also help you clarify your thoughts and feelings about what brings you to therapy at this time in your life, and what you want to focus on and accomplish. **This is definitely a lengthy form, please plan accordingly**. Please, do not write more information than the space allows for. We will cover all aspects of concerns as we work together.

Rest assured that all of that you share here will be kept confidential to the extent of the law, and as described in the "Psychotherapy Informed Consent Form". To help us make the most of our initial session together, I will read this form between our first and second meeting.

I look forward to meeting you soon.
Sincerely,

Nathan Bergeron, LMFT, L.Ac.

PSYCHOTHERAPY INDIVIDUAL INTEGRAL INTAKE FORM

(If you wish not to fill up this entire form, please still complete the first two pages.)

Name:_____Date:_____
Home #:_____ Cell #:_____
Address:_____ City:_____ Zip:_____
Gender: □F □M □TGNC DOB:_____ Age:____ Height:_____ Weight:_____
Email:_____ Driver Lic:_____
Sexual Orientation: □straight □bisexual □gay/lesbian □queer/non conformist
□asexual □uncertain □_____
Ethnicity: □Asian □African □African A. □Caucasian □Hispanic □Indian □Latino
□Middle Eastern □Native A. □Pacific Islander □Other:_____
Country of birth:_____ If not USA, moved @ age/yr:_____/_____
Relationship status: □single □dating □open □exclusive □living together
□engaged □married □married w/ children □separated □widow □_____
If relationship, together since:_____ Quality of rel: _____
_____
If □separated or □widow, date_____ and how did/does it affect you:_____
_____
Occupation:_____Place of work: _____
Role & responsibilities at work:_____
Emergency Contact:_____ Relation to you:_____
(address, phone #, email):_____
_____
Primary Care Physician (name, address, phone #, email):_____
_____
Psychiatrist (name, address, phone #, email):_____
_____
List of medications presently taking, (dosage/amount and what the medication is or):_____
_____
_____
Referral Source:_____
OK to thank him/her? □Yes □No If yes, only the fact that you contacted me will be acknowledged.
NOTHING about the content of our work will ever be discussed or shared with anyone without your written permission. (See "Informed Consent Form")

What is the primary concern, or reason(s) for which you are seeking therapy?

Why now?

What makes your situation better?

What makes your situation worse?

What do you need, and wish from our work together?

Are there any immediate challenges, or issues that need our attention? □No
If yes, please describe.

Have you ever had counseling or psychotherapy before? □No
If Yes, when and for how long?

What was most helpful?

What was least/not helpful?

What strengths, qualities and resources do you value most in yourself?

What are some of your personality traits which you consider flaws or challenging?

What support system do you have (family, friends, social, political, spiritual/religious, etc.)?

How would you describe your general mood?

What are the most challenging and strongest emotions you experience?

How do you care for, and comfort yourself when you feel distressed?

How do you go about making difficult or challenging decisions? (□logic, □reason, □gut, □feelings, □intuition, □heart, □advices, □trusted ones, □prayer, □meditation, etc.)?

_____

_____

Have you ever attempted to harm yourself? □No If yes, please describe.

_____

_____

Have you ever attempted to harm someone? □No If yes, please describe.

_____

_____

Have you in the recent past, or are you currently experiencing suicidal thoughts? □No If yes, please describe.

_____

_____

List your ***Family of origin*** (family you grew up with), beginning with parents from oldest to youngest, including yourself and your place in the family.

name gender/age relationship to you adopted-biological-step-half Alive-Deceased (when?)

_____

_____

_____

_____

_____

_____

Parents marital status throughout their relationship: □always been together, □separated, □divorced, □returned together after □separation or □divorce, □mother widow, □father widow, □mother-□father involved w/ someone else, □mother-□father remarried// Other important information about parents:

_____

_____

Were some members of your family of origin □only present for part of your childhood, □not present at all? If so, please explain:

_____

_____

Were there special circumstances in your childhood?

_____

_____

Which emotions were most commonly expressed in your **family of origin**?

_____

_____

Which emotions were □discouraged, □prohibited, □shamed, □_____ in your **family of origin**, and what happened when they were expressed?

_____

_____

If you don't live alone list, from oldest to youngest (yourself included), your **current family system/ or the people you currently live with.**

name gender/age relationship to you adopted-biological-step-half

_____

_____

_____

_____

_____

_____

_____

Do you □drink alcohol □have problems with alcohol consumption □alcohol intoxication □alcohol brownout □alcohol black out □have friends/family members/ co-workers, etc. commented on your alcohol consumption? □No
If so, please describe what motivates you to drink, frequency and quantity:

_____

_____

_____

Do you □use recreational drugs, □prescribed, □not prescribed? □No
If yes, please describe which one(s), frequency & quantity.

_____

_____

_____

Do you struggle with any forms of addictive behaviors such as □bulimia □dieting □sugar □coffee □nicotine □prescription drugs □shopping □working □gambling □porn □sex □working out □other: _____ □No If so, please elaborate.

_____

_____

_____

Sleeping patterns: What time do you usually go to bed? How long does it take before you fall asleep? How many hours per night do you sleep? Do you sleep straight through the night, or wake up throughout the night, and if so, how many times? What time do you wake up? Do you feel rested upon waking? etc.?

_____

_____

_____

Describe your usual eating habits (types of food, frequency, times between meals, quantity):

_____

_____

_____

Do you take □vitamins, □nutritional supplements? □No If yes, which one(s) and for what?

_____

_____

_____

While you were growing up, **during your first 18 years of life**:

1. Did a parent, other adult or someone significantly older than you in your household often or very often…
   * Swear at you, insult you, put you down, or humiliate you? □ yes / □ no
   * Act in a way that made you afraid of being physically hurt? □ yes / □ no

2. Did a parent, other adult or someone significantly older than you in your household often or very often…
   * Push, grab, slap you, or throw something at you? □ yes / □ no
   * Ever hit you so hard that you had marks or were injured? □ yes / □ no

3. Did an adult, or a person older/ stronger/ more powerful than you ever…
   * Touch or fondle you, or have you touch their body in a sexual way? □ yes / □ no
   * Attempt, or actually have oral, anal, or vaginal intercourse with you? □ yes / □ no

4. Did you often or very often feel that…
   * No one in your family loved you or thought you were important or special? □ yes / □ no
   * Your family didn't look out for each other, feel close or support each other? □ yes / □ no

5. Did you often or very often feel that…
   * You didn't have enough to eat, had to wear dirty clothes and had no one to protect you? □ yes / □ no
   * Your parents were too drunk/high/preoccupied/absent to take care of you or take you to a doctor if you needed it? □ yes / □ no

6. Did you lose a parent due to separation, divorce, or death? □ yes / □ no

7. Was one of your parent, step parent, or primary caretaker…
   * Often or very often pushed, grabbed, slapped, kicked, bitten, hit with fist/something hard, or had something thrown at him/her? □ yes / □ no
   * Threatened with a gun or knife? □ yes / □ no

8. Did you live with anyone w/ a drinking or drug problem? □ yes / □ no

9. Was a household member depressed or mentally ill, or attempted suicide? □ yes / □ no

10. Did a household member go to prison? □ yes / □ no

Other comments:_____

_____

_____

(For more information on the importance of these questions, feel free to read my ***BLOG on The ACE STUDY*** published 06.01.2016)

Do you engage in some form of physical exercise? □No If yes, please describe kind of exercise(s), frequency, duration, and intensity:

_____

_____

_____

Are you sexually active? □No If so, how satisfied are you sexually?

_____

_____

What beliefs do you have about sex? How important is sex to you?

_____

_____

What are some of your most important moral and ethical values?

_____

_____

Do you have a □religious affiliation □spiritual affiliation? □No
If yes, please describe its importance and role in your life:

_____

_____

Are money and financial matters significant stressors in your life? □No
If yes, please describe:

_____

_____

Do you have any concerns about your □home environment, □neighborhood, (□unsafe □stressful □loud, etc.)? □No If yes, please explain:

_____

_____

What is your: (read below), and how old were you when it happened? What emotions/feelings did you feel then? What emotions/feelings do you feel now when think of it?

Earliest memory: _____

_____

Earliest dream: _____

_____

Earliest nightmare: _____

_____

Happiest memory: _____

_____

Most painful memory: _____

_____

Most impactful event(s) which affected the unfolding of your life: _____

_____

_____

_____

_____

How satisfied are you with your life? Comments
Not at all 1 2 3 4 5 6 7 Very _____

How do you feel about yourself (self-esteem)?
Not at all 1 2 3 4 5 6 7 Very _____

How would you rate your physical health?
Not at all 1 2 3 4 5 6 7 Very _____

How satisfied are you with your friendships?
Not at all 1 2 3 4 5 6 7 Very _____

How comfortable are you in social situations?
Not at all 1 2 3 4 5 6 7 Very _____

How satisfied are you with your work situation?
Not at all 1 2 3 4 5 6 7 Very _____

How satisfied are you with your standard of living?
Not at all 1 2 3 4 5 6 7 Very _____

How satisfied are you with your personal/intimate relationship(s)?
Not at all 1 2 3 4 5 6 7 Very _____

From the list below, please mark the emotions and state of mind you currently experience more frequently/ intensely, or have experienced in the recent past:

□ Lonely □ Isolated □ Anxious □ Worried □ Jealous □ Indifferent
□ Optimistic □ Pessimistic □ Often overly excited □ Depressed □ Sad
□ Afraid □ Shameful □ Guilty □ Frustrated □ Irritability □ Loose temper
□ Mood swings □ Very energetic/ □ tired □ Excessive/ □ Poor appetite
□ Needing less/ □ more sleep □ Thoughts/ □ Behaviors to harm yourself
□ Thoughts/ □ Behaviors to harm others □ Racing/ □ Obsessive thoughts
□ Difficulty focussing □ Little interest/ □ pleasure in doing things
□ Spend more money than you can afford □ Think you would be better off dead
□ Hearing/ □ Seeing/ □ Smelling things that are not actually there
□ Disturbing images of past traumatic experiences you experienced yourself
□ Disturbing images of past traumatic experiences you witnessed
□ Neglect self □ Poor grooming □ Neglect significant other □ Family □ Friends
□ Other emotions, thoughts, feelings you'd like me to know me about:

_____

_____

□ Are you currently □ Have you ever been a **victim** of □mental □verbal □emotional □physical □sexual abuse? □No If yes, please elaborate:

Have you ever **witnessed** □mental □verbal □emotional □physical □sexual abuse? □No If yes, please elaborate:

Have there been any serious □health issues □mental issues □major losses or □changes in your □family of origin, □current family that have affected you? □No If yes, please describe.

Has anyone in your □family □close to you □threatened to commit suicide □attempted suicide □committed suicide? □No If yes, please describe:

Has anyone in your □family □close to you □threatened to commit a homicide □attempted a homicide □committed a homicide? □No If yes, please describe:

Are you currently involved in a custody dispute? □No If yes, please describe situation and how it is affecting you:

Is there anything else that you would like me to know?