Rev Dr. Christopher Ryan, D. Min., MSW, LICSW,
CEAP, SAP
c/o Inner Life Counseling & Consulting, LLC
1800 Elm Street
Manchester, NH 03104
603-391-6547
www.innerlifecc. com

INTAKE

Name _____ Date _____

SS# _____ Marital Status _____

DOB _____ AGE _____ Referred By

Mailing Address

Home Phone/Cell Phone
H: C: Email:

Daytime Phone best to reach you (can a message be left for you?)

Primary Care Physician _____

Physician's Phone # and Address _____

Employment Information

Current Employer(s) _____ Occupation
Work Address

Work Phone

Family Information
(fill out parent information even if treatment is for child)

Name of Spouse or Partner _____
Spouse's Date of Birth _____
Spouse's Employer/Occupation _____
Spouse's Work Phone_____
Children (Names/Ages) _____
Do your children currently reside with you?
If married, is this your first marriage? _____ If divorced, when did you divorce.

Medical History
(if for child, please include all family illness)

Please indicate significant physical illnesses, injuries or emotional conditions (Past or Present)

Have you experienced any severe trauma or critical incident/loss (abuse, neglect, car accidents, etc.)?
_____YES_____ NO
Weekly Alcohol Consumption _____
Other Drug Consumption _____
Addiction History, including drugs, alcohol, sexual, computer, gambling, other (including brief family history of addiction):

Medications You Are Currently Taking_____
Prescribing Physician(s) _____
Do You Have Any Allergies (Foods, Drugs, etc.)? _____
Are You in Excellent _____Good _____ Fair _____ Or Poor_____ Health?
Do You Experience Degrees of Mood Changes?_____ If so, When and How Often?_____

Previous Counseling or Psychotherapy

Have you ever been in professional counseling or psychotherapy before (including school):
YES_____No _____
IF YES:
When Did You First Begin Counseling _____
How Long Were You in Treatment _____
Who Was Y our Counselor (optional) _____

In Your Previous Counseling What Issues Do You Feel You:
A.) Resolved B.) Partially Resolved And/Or C.) Did Not Address? (Why?)

A.)_____
B)_____
C)_____

Have You Ever Seriously Considered Suicide? If Yes, When and Why?

What Are Your Present Goals in Counseling?

A.)_____
B)_____
C)_____

Stress Management Skills

Do You Exercise Regularly? Yes_____ No _____ Type of Exercise _____
Give An Example Of The Kinds Of Food You Eat On A Normal Day

Do You Consider Yourself To Be Under Low, Moderate, or High Levels of Stress?

Do You Regularly Do Anything To Help Yourself Relax, Such As: Prayer, Meditation, Yoga, BioFeedback, Stress Reduction Techniques, etc.? (please specify and how often?)_____

Do You Have Someone You Can Express Your Feelings With? Yes _ No If Yes, Who:

Do you read for personal growth?

Religious/Spiritual Beliefs

Do You Have Any Personal Religious and/or Spiritual Beliefs or Practices? Y es _____No_____
If Yes, Please Provide A Description Of What Faith You Prescribe To, And How Present It Is In Your Life? _____
If you are part of a local Church, which Church do you attend and how are you involved? _____
If Yes, Do You Desire To Have Spirituality and/or Faith Integrated In Your Counseling? _____
If so, how?

Personal History

Write A Brief Personal History And Include The Following:

A. Your parent's relationship to each other and your relationship to each parent.

B. Your relationship to your siblings.

C. How did You Feel About Your Upbringing? Did you feel socially accepted?

D. Describe Your Present Living Situation And Significant Relationships.

(If more space is needed continue on back of page)

Education/Schooling

What Was The Highest Grade/Degree You Completed? _____

Was there any break in the sequence of your school advancement? (ex. "stayed back" a year) If so, when? _____

Did You Feel Socially Accepted As You Were Growing Up and Do You Now?

Briefly Describe Your Last Three Work Experience s _____

CLIENT CONCERNS CHECKLIST

Name_____ Date _____

Directions Please rate ALL the following on a scale of 0 - 10.
0 - no concern 5 - moderate concern 10 - major concern

L Anxiety _____ .
2. Depression _____
Describe _____ _____ _____Suicidal thoughts? _____
3 Disturbing thoughts
4, Fcars/fearfutness _____
Describe _____
5 Angry outbursts (temper)
6, Eating problems _____
Desc ribc_____
7, Sleep problems _____
Describe _____
3, Fatigue _____
9 Sexual problems
Describe _____ _____
10 Alcohol, drug, or nicotine concents _____
Dcscn be _____
11. Stress _____
Causes o f that stress_____

12. Work or school problems _____
Describe _____ _____ _____ _____
13. Family problems_____
Describe _____
14. Chi Id-rearing problems _____
Describe _____
15. Cent ml relationship problems _____
Describe _____
16 Violence _____
Describe _____ .____ _____ _____
17. Health problems _ _____ _
Describe _____
13, Legal problems_____
19 financial problems____ _____
20. Religious/spiritual concerns _____
21. Other addictive behaviors (re. gambling, spending, workaholism, etc.)
Describe _____
22. Other problem ___ ___
Describe _____