

The Emmaus Center
Counseling in the Catholic Tradition
Intake Assessment

Please take some time before your appointment to print and complete this form. This will allow us the best use of time during your session. **All information you provide here is protected as confidential information.**

Name: _____

Home Parish: _____

Name of parent/guardian (if under 18 years) _____

Date of Birth _____/_____/_____ Gender _____

Marital Status Never Married Married Divorced Separated Widowed

Please list any children and their ages: _____

Address: _____

Home phone () _____ Cell phone () _____

Email address _____

Please note: email correspondence is not considered to be a confidential medium of communication

How would you like to be contacted for appointment reminders or scheduling changes: _____

Referred by (if any) _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc)?
No Yes, previous therapist _____

Are you currently taking any prescription medication? Yes No

Please list: _____

Have you ever been prescribed psychiatric medication: Yes No

Please list and provide dates: _____

General Health and Mental Health Information

1. How would you rate your current physical health? Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your current sleeping habits? Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

3. How would you rate your prayer life? Poor Unsatisfactory Satisfactory Good Very good

Please list any spiritual concerns you currently have:

4. Do you regularly attend Mass or Sunday Services? Yes No

5. Do you have private prayer time each day? Yes No

6. How many times per week do you generally exercise? _____

7. Please list any difficulties you experience with your appetite or eating patterns

8. Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

If so, for approximately how long? _____

9. Are you currently experiencing anxiety, panic attacks, or phobias? Yes No

If so, for approximately how long? _____

10. Are you currently experiencing chronic pain? Yes No

If so, please describe: _____

11. Do you drink alcohol more than once a week? Yes No Do you feel that your alcohol use has caused problems in your life? Yes No

12. How often do you engage in recreational drug use? Daily Weekly Monthly

Infrequently Never 3

13. Please describe any significant life changes or stressful events you have experienced recently.

14. On a scale of 1 to 10, how would you rate your life right now? _____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

_____ List relationship _____

Alcohol/Substance Abuse	<input type="radio"/> Yes	<input type="radio"/> No
Anxiety	<input type="radio"/> Yes	<input type="radio"/> No
Depression	<input type="radio"/> Yes	<input type="radio"/> No
Domestic Violence	<input type="radio"/> Yes	<input type="radio"/> No
Eating Disorders	<input type="radio"/> Yes	<input type="radio"/> No
Obesity	<input type="radio"/> Yes	<input type="radio"/> No
Obsessive Compulsive Behavior	<input type="radio"/> Yes	<input type="radio"/> No
Schizophrenia	<input type="radio"/> Yes	<input type="radio"/> No
Suicide Attempts	<input type="radio"/> Yes	<input type="radio"/> No

Additional Information

1. Are you currently employed? Yes No

If yes, describe your current employment situation: _____

2. What do you consider to be some of your strengths? _____

3. What do you consider to be some of your weaknesses? _____

4. What would you like to accomplish during your sessions at the Emmaus Center?
