



Crosswinds Counseling
Amy Hertle MSW LICSW

1895 E Co Rd E, White Bear Lake, MN 55110
crosswindscounseling@gmail.com
(651) 890-6031

GENERAL INFORMATION & INTAKE

General Information

Today's date: _____

Client name _____ DOB: _____ Age: _____

Home Address _____

_____ State _____ Zip _____

Home phone: _____ Okay to call? Y N Okay to leave message? Y N

Cell phone: _____ Okay to call? Y N Okay to leave message? Y N

Work phone: _____ Okay to call? Y N Okay to leave message? Y N

Email: _____ Okay to email? Y N

If under 16: mother's name _____ father's name _____

Marital Status S M D W Other _____

Current status: Student Employed Unemployed Homemaker Retired Other: _____

If student, are you Full Time or Part Time? FT PT School attending _____

If working, please give Occupation and Place of Employment _____

Emergency contact _____ Relationship _____

Emergency contact Phone Number _____

If person filling out form is not client, check here: What is your relationship to client? _____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

2. Did a specific event lead to this request for service? If yes, please describe: _____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy:

4. How long has this problem been present: _____

5. What solutions to the problem have you tried, and what were the results: _____

6. How much does this problem affect your life? (Please circle the number that best applies)

	Not at all	A little bit	A lot	All the time
Personally	1	2	3	4
Family Life	1	2	3	4
Socially	1	2	3	4

c. Suicidal thoughts, plans, or attempts 1 2 3 4

d. Have you ever thought about, planned or attempted suicide?

Thought about: Y N Planned: Y N Attempted: Y N

If yes to any of these, when was this? _____

Not at all Mildly Moderately Severely

e. Changed sleep patterns: 1 2 3 4

Difficulty falling asleep: Y N Difficulty staying asleep: Y N

Can't get up in a.m.: Y N Nightmares: Y N

f. Change in weight or eating habits: 1 2 3 4

Increase: Y N Decrease: Y N

g. Loss of interest or energy: 1 2 3 4

h. Anxious, nervous, or panicky feelings: 1 2 3 4

i. Avoiding places or situation: 1 2 3 4

j. Repetitive thoughts or behaviors: 1 2 3 4

k. Change in work habits: 1 2 3 4

l. Anger or temper problems: 1 2 3 4

m. Insecurity or inferiority: 1 2 3 4

n. Physical problems, pain, or illness: 1 2 3 4

o. Sexual worries or problems:	1	2	3	4
	Not at all	Mildly	Moderately	Severely
p. Change in spending habits:	1	2	3	4
q. Memory problems:	1	2	3	4
r. Confused or disorganized thoughts:	1	2	3	4
s. Hallucinations:	1	2	3	4

Mental Health & Medical History

12. Who is your primary care physician and your primary clinic? _____

13. Who else do you regularly see as part of your routine health care: _____

14. List any significant health problems, past or present, including surgeries and/or illnesses with the corresponding dates:

15. Are you currently taking any medications? Yes No If yes, please list:

16. Have you ever taken any medications for depression, anxiety, or mental health issues? Yes No If yes, please list medication name and reason prescribed: _____

17. List other therapy or counseling you have received in the past or are receiving now:

18. Have you ever been hospitalized for mental or nervous problems? Yes No

If yes, when and where? _____

Substance Use

19. Please describe your use substances (Caffeine, Tobacco, Alcohol, Prescription drugs, Inhalants, Street drugs, Over-the-counter medications, Other) and frequency of use Daily, Weekly, Occasionally, In the past but not now):

20. Have you ever experienced any of the following as a result of substance use?

Blackout Bad reactions Withdrawal symptoms Overdose DUI Other: _____

Please give details: _____

21. Have you ever felt you should cut down on your drinking or drug use? Yes No

22. Have other people stated you should cut down on your drinking or drug use? Yes No

23. Have you ever felt bad or guilty about your drinking or drug use? Yes No

24. Have you ever had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, get rid of a hangover, or to get the day started? Yes No

25. Have you ever had treatment for any type of alcohol or substance use? Yes No

If yes, please describe: (Include inpatient, outpatient, detox) _____

Resources

26. What has helped you manage or endure your current problem? _____

27. Please describe the people in your life that currently play a supportive, influential, or friendship role. _____

28. What interests or passions give meaning to your life? _____

29. Do you have any spiritual beliefs or practices that are important to you ? _____

30. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? _____

Family Information

31. Please list those who you consider part of your immediate family and/or your current household.

32. Please indicate which factors are present in your current family and were present in the family you grew up in:

a. Separation or Divorce (please circle which)

Who: _____ What year(s): _____

b. Remarriage:

Who: _____ What year(s): _____

c. Death of an immediate family member:

Who: _____ What year(s): _____

d. Abuse: (Please circle all that apply) Physical Verbal/Emotional Sexual Neglect:

Who: _____ What year(s): _____

e. Physical health problems:

Who: _____ What year(s): _____

Describe: _____

f. Mental health problems:

Who: _____ What year(s): _____

Describe: _____

g. Loss of employment:

Who: _____ What year(s): _____

h. Alcohol or Substance abuse or addiction:

Who: _____ What year(s): _____

Describe: _____

Other

33. Is there anything else that you would like your therapist to know and that you have not written about on any of these forms? Yes No If yes, please tell me about it here or on another paper: _____

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform Amy Hertle of any changes in my personal circumstances including address, symptoms experienced, suicidal thoughts and substance use.

Client Signature _____ Date: ____/____/____