BURKE COUNSELING, PLLC

2505 Larkin Rd. Suite 104
Lexington KY, 40503
859-803-7857
katrinaburke@burkecounseling.org

INTAKE INFORMATION PROFILE
All information is confidential.

GENERAL INFORMATION

Name _____ Age _____ Gender _____

Occupation _____ Employer _____

Address _____

Home Telephone _____ Cell _____ Work _____

Marital Status: Married _____Divorced _____ Widowed _____Separated _____Single ____

Education: High School (last grade completed) _____College _____ (how many years)

Other Training? (list type and years) _____

HEALTH INFORMATION

Please rate your physical health: Very good _____Good _____Average ____Declining ____

Recent weight changes: Lost _____Gained _____

List important present or past illnesses or injuries _____

_____

Physician's name _____Date of last exam? _____

Presently taking medication? _____ If so, what? _____

For what reason are you taking the medication? _____

Have you been treated by a psychiatrist? Yes_____No_____Date of treatment_____

How long? _____ Name of psychiatrist, if applicable_____

SPIRITUAL INFORMATION

Currently attend/member of a church? Yes____No____ If yes, name of church_____

How long? _____Times per month attending _____

Religious background of spouse? _____Does your spouse attend with you?_____

Other religious background? _____

On a scale of 1-10 (ten being highest) rate your present relationship

with God _____ with prayer _____ with Bible study _____

EMOTIONAL INFORMATION

Have you ever had a severe emotional upset or trauma? _____Explain _____

_____

Have you ever had counseling in the past? Yes _____No _____

If yes, list counselor or therapist and dates _____

_____

What was the outcome? _____

Please circle the following words which best describe you now

active	impatient	calm	serious	leader	ambitious
impulsive	submissive	easy-going	quiet	self-confident	persistent
moody	often blue	likable	lonely	shy	good-natured
nervous	excitable	sensitive	introvert	hardworking	imaginative
depressed	self-conscious				

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ____Yes ____ No

If YES, please answer the following. If NO, please skip to the "Substance Abuse" section.

Do you currently feel that you don't want to live? ____Yes ____No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1-10 (10 being strongest), how strong is your desire to kill yourself currently_____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain _____

Substance Abuse:

Do you use caffeine? ____ Amount per day? _____ Alcohol? ____Amount per day? _____

Recreational drugs? _____ If so, what substances? _____

Please list any other addictions: _____

MARITAL INFORMATION

Spouse's Name_____Age_____Phone_____

Address_____Occupation_____

Education H.S. ____College How many years? ____ Willing to come for counseling? _____

Has either of you filed for divorce? _____ Date of marriage? _____

Your ages at marriage: His_____ Hers_____ Length of dating_____ Engagement_____

Number of previous marriages: His _____Hers _____

Children's names and ages: _____

FAMILY OF ORIGIN INFORMATION

Were you reared by anyone other than your birth parents? Yes_____No_____ If yes, please explain_____

_____

Did one or both of your parents die while you were a child? ____ How old were you?_____

Are your parents divorced? Yes_____No_____When_____

Age of parents, if living: Mother _____Father _____

Father's occupation _____ Mother's occupation_____

Was your parents' marriage: _____unhappy _____average _____happy _____very happy

As a child were you closest to: ____father _____mother _____someone else (whom?) _____

Was your childhood _____unhappy _____average _____happy _____very happy

Please list your siblings in birth order, giving their age and including yourself in the list _____

_____

EXPECTATIONS FOR COUNSELING

What brings you here at this time? _____

_____

Have you done anything about this concern so far? Yes____No____ If so, please explain_____

_____

_____

What do you hope to get from this counseling experience? _____

_____

Other information you feel I should know _____

_____

May I contact you by email? Yes ___No ____ If so, please provide your email address

_____