Rape Response Counseling Services

New Client Intake Form

File #

Full Name: _____ Date of Birth: _____

Age: _____ Preferred Name: _____

Parent/Guardian for Minors: _____ Relationship: _____

Address: _____

County of Residence: _____

Phone #: _____ Email: _____

Is it safe to contact you at the number above? _____

Is it safe to leave scheduling information on the email you provided? _____

Emergency Contact and Phone number

_____

What other method of communication do you prefer? _____

How did you hear about Rape Response, Inc? _____

County of Incident: _____Approximate Date of Incident(s)_____

Was the incident reported to police? _____ Is there an open investigation? _____

Did you receive medical care after the incident(s)? _____ SANE exam? _____

Briefly, describe what you want me to know about you and your situation.

_____

_____

_____

_____

_____

_____

_____

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Please mark yes to symptoms that match your experience	Yes	Please mark yes to symptoms that match your experience	Yes
Feelings of guilt		Separation/divorce	
Feeling disoriented to time or place		Death of a loved one/loss/grief	
Paranoia		Being verbally abusive to others	
Disorganized thinking		Being verbally abused	
Suicidal thoughts		Being physically abusive to others	
Self-harming urges		Being physically abused	
Low self-esteem		Being sexually abusive to others	
Obsessing over things		Being sexually abused	
Thought disturbances		Legal problems	
Racing thoughts		Career problems	
Difficulty concentrating		Gambling	
Self-distaining thoughts		Substance use/abuse/addiction	
Overeating		Relationship problems	
Binging/purging		Poor boundaries	
Loss of appetite		Aggressive behaviors	
Traumatic flashbacks		Isolating behaviors	
Difficulty sleeping		Difficulty having sexual relations	
Nightmares/strange dreams		Passive behaviors/fear of speaking up	
Decline of motivation		Seeking approval	
Fatigue		Violent thoughts or outbursts	
Memory loss		Stealing/Lying/Cheating	
Crying spells		Impulsive behaviors	
Depression		Financial problems	
Anxiety/worry		Homicidal thoughts	
Envy/jealousy		Dissociating	
Shame		Spiritual/religious problems	
Anger/hostility		Hair pulling	
Loneliness		Fear of rejection	

What experiences or symptoms seem the most urgent to discuss in therapy?

_____

_____

_____

_____

_____

_____

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Have you been in therapy before?**	Yes	No
If yes, please describe: _____		
Do you have any medical problems?**	Yes	No
If yes, please describe: _____		
Are you currently prescribed medication?**	Yes	No
If yes, please describe: _____		
Do you have a known mental illness?**	Yes	No
If yes, please list: _____		
Do you experience thoughts of hurting yourself?	Yes	No
Are you committed to treatment?	Yes	No

**If you are prescribed medication or seeking therapy from another provider, it may be helpful to give me permission to communicate with that provider. If you consent to communication between me and another healthcare provider, please complete the HIPAA Privacy Authorization Form.

I have read and understand the Consent to Counseling form as well as all other documents provided to me. I have given truthful information to the best of my knowledge on all forms provided to me.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

Supervisor _____ Date _____

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Race (select all that apply) Native American/ Alaskan Asian Black/African American Caucasian Native Hawaiian/Pacific Islander Declined	**Hispanic Ethnicity** (select all that apply) Cuban Mexican Puerto Rican Other Hispanic Declined Not Applicable	**Gender identity** Female Male **Sexual Orientation** ☐ Bisexual ☐ Gay/Lesbian ☐ Heterosexual ☐ Other ☐ Declined

Marital Status ☐ Never Married ☐ Married ☐ Married, separated ☐ Divorced ☐ Widowed	**Living Arrangement** (select all that apply) ☐ Alone ☐ With Partner/significant other ☐ With Spouse ☐ With Children ☐ With Mother ☐ With Father ☐ With Sibling(s) ☐ With relatives ☐ With unrelated people

Family Members in Home:

Name(s)	*DOB or Age*	*M or F*	*Relationship to Client*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Primary Role ☐ Employed (Full time 35+ hours/week) ☐ Employed (Part time 35 or less hours/week) ☐ Unemployed	**Highest Education Level Completed:** ☐ Below 9th grade: ☐ Between 9th and 11th grade: ☐ 12th grade or GED ☐ Some college ☐ College degree ☐ Master's degree ☐ Doctoral degree	**Previous or Current Services** (check all that apply): ☐ Juvenile Justice ☐ Adult Corrections ☐ Developmental Disabilities and/or Special Education ☐ Child Welfare ☐ Mental Health and/or Substance Abuse Treatment

Are you currently in school? ☐ Yes ☐ No
If yes, what grade are you in? _____

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Forms Checklist (office use only)

Form	Date Completed	Outcome	Signature
PCL-5			
LEC-5			
HIPAA PAF			
Demographic			
Disclosure/Agreement			
Adolescent Consent			