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COUNSELING

Intake Form

Please fill out this form and bring it to your first session. Please answer all questions and note that the information you provide here is protected as confidential information.

Name: ____
(First) (Middle) (Last)

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

____
(First) (Middle) (Last)

Birth Date: _________ /_________ /_________ Age: ___________

Social Security Number: ______________________________

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Occupation: ____

Please list any children/age: ____

Address: ____
(Street)

____
(City) (State) (Zip)

Home Phone: ( ) - Cell/Other Phone: ( ) -
May I leave a message? □ Yes □ No May I leave a message? □ Yes □ No

E-mail: _____________________________________ May I email you? □ Yes □ No (*Please note: Email correspondence is not considered to be a confidential medium of communication.)

Emergency Contact Information:
Name: _______________________________________ Relationship:________________
Cell phone/other: ______________________________

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

____

Are you currently taking any prescription medication(s)? □ Yes □ No
Please list all:

____

____

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? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Please list any specific health problems you are currently experiencing:

____

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Please list any specific sleep problems you are currently experiencing:

____

____

3. How many times per week are you physically active? _________________________

What types of activities do you participate in? ________________________________

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

____

5. Are you currently experiencing overwhelming sadness or grief? □ No □ Yes

If yes, for approximately how long? ____

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

If yes, when did you begin experiencing this? ________________________________

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____
8. How often do you drink alcohol? ________ times per week ________times per month

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
Type of substance(s) used:____

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 (parent, sibling, grandparent, aunt, uncle, etc.)

Alcohol/Substance Abuse □ No □ Yes ____

Anxiety □ No □ Yes____

Depression □ No □ Yes____

Domestic Violence □ No □ Yes ____

Eating Disorders □ No □ Yes____

Obesity □ No □ Yes ____

Obsessive Compulsive Behavior □ No □ Yes ____________________________

Schizophrenia □ No □ Yes ____

Suicide Attempts□ No □ Yes ____

Completed Suicide□ No □ Yes ____

Please describe what has brought you to therapy at this time:

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