Intake Information

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Name of Client: _____ Date:_____
Parents' or Guardian's Name (if under 18):_____

Signature of Legally responsible adult: _____
Date of Birth of Client: _____ Age:_____ Gender: □ Male □ Female
Address: _____
City: _____State:_____ Zip Code:_____

Home Phone: _____ May we leave a message? □ Yes □ No
Work Phone: _____ May we leave a message? □ Yes □ No
Cell Phone: _____ May we leave a message? □ Yes □ No

Email Address: _____ May we email you? □ Yes □ No
***Please note: Email correspondence is not considered to be confidential medium of communication.**

Please circle one: Married Single Separated Divorced Widowed Domestic Partnership
Spouse's Name: _____ If married, how long? _____ If Divorced, how long? _____

Employer: _____
Spouse's Employer: _____ Work Phone: _____
Note: Please complete the Insurance Form if applicable.

Referred by (if any): _____
Person to contact in case of emergency: _____ Telephone: _____

Other persons currently living in your house:
Name: _____ Age:_____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Any children not living in the household? _____

Please circle type(s) of counseling in which you are interested:

Marital Individual Group Family Play therapy Other: _____

Have you previously received any type of mental health services (counselors, therapist, psychiatric services, etc) in the past two years?
□ No
□ Yes, previous therapist/counselor: _____Phone : _____

Are you currently taking any prescription medication?
□ No
□ Yes, Please list

Medications:	Prescribed for:	Prescribing Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any inpatient treatment you may have received: _____
_____

Name of primary physician: _____Phone Number:_____
Name of psychiatrist (if applicable): _____ Phone Number:_____

Any history of depression, anxiety, substance abuse, mental illness, etc. in the family? □ Yes □ No
If Yes, please explain: _____
_____

In your own words, please describe your major concern that led you to seek help?
_____
_____
_____

GENERAL HEALTH AND MENTAL INFORMATION (For the Client)

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you are currently experiencing:
   _____

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

   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing:
   _____

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

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

5. Are you currently experiencing overwhelming sadness, grief, or depression?
   □ No
   □ Yes, - for approximately how long? _____

6. Are currently experiencing anxiety, panic attacks, or have any phobias?
   □ No
   □ Yes, - when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
   □ No
   □ Yes, - please describe: _____

8. Do you drink alcohol more than once a week? □ Yes □ No

9. How often do you engage in recreational drug use?
   □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ Yes □ No
    If yes, for how long? _____

11. What significant life changes or stressful events have you experienced recently?
    _____
    _____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ Yes □ No
   If yes, what is your current employment situation? _____

   Do you enjoy your work? Is there anything stressful about your current work?
   _____
   _____

2. Do you consider yourself to be spiritual or religious? □ Yes □ No
   If yes, describe your faith or belief:
   _____
   _____

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

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

5. What would you like to accomplish out of your time in counseling?
   _____
   _____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes regarding the above information.

SIGNATURE: _____ DATE: _____