

COUNSELING INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth/Place:	Relationship Status:
Age:	SSN:
# of Dependents:	Gender: M / F
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address:	
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
Highest Grade/Degree:	Type of Degree:
Medical Doctor's Name:	Medical Doctor's Phone #:
Psychiatrist's Name:	Psychiatrist's Phone #:
Primary Insurance:	ID #:
Group #:	Subscriber Name:
Insurance Phone:	Subscriber DOB:
Emergency Contact Name:	Subscriber SSN:
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Current Concerns:

What concern brings you in? Estimate the severity of this concern: Mild Moderate Severe Very Severe

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Behavior – circle any of the following behaviors that apply to you:

- | | | | | |
|------------------|---------------------|-------------------|---------------------|----------------------------|
| Overeat | Suicidal attempts | Can't keep a job | Take drugs | Compulsions |
| Insomnia | Vomiting | Smoke | Take too many risks | Odd behavior |
| Withdrawal | Lack of motivation | Drink too much | Nervous tics | Eating problems |
| Work too hard | Procrastination | Sleep disturbance | Crying | Impulsive reactions |
| Phobic avoidance | Outbursts of temper | Loss of control | Aggressive behavior | Concentration difficulties |

Feelings – circle any of the following feelings that apply to you:

- | | | | | | | |
|------------|----------|-----------|-----------|---------|----------|------------|
| Angry | Guilty | Unhappy | Annoyed | Happy | Bored | Sad |
| Conflicted | Restless | Depressed | Regretful | Lonely | Anxious | Hopeless |
| Contented | Fearful | Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous | Others: | |

Physical – circle any of the following symptoms that apply to you:

- | | | | | |
|---------------------|-----------------|--------------------|-----------------------|--------------------------|
| Headaches | Stomach trouble | Skin problems | Dizziness | Tics |
| Dry mouth | Palpitations | Fatigue | Burning or itchy skin | Muscle spasms |
| Twitches | Chest pains | Tension | Back pain | Rapid heart beat |
| Sexual disturbances | Tremors | Unable to relax | Fainting spells | Blackouts |
| Bowel disturbances | Hear things | Excessive sweating | Tingling | Watery eyes |
| Visual disturbances | Numbness | Flushes | Hearing problems | Don't like being touched |

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Past/present medical conditions and treatment outcome, if any:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Medication	Dose	For what?	By whom (psychiatrist, endocrinologist, etc.)
------------	------	-----------	---

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Your relationship with your brothers and sisters, in the past and present:

Name Age/Year of Death & Cause Brief Statement about the Relationship

Children/Step/Grand (names and ages & brief statement on your relationship with the person):

Abuse History: I was not abused in any way I was abused

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Chemical Use:

- Have you ever felt the need to cut down on your drinking? ___ No ___ Yes
- Have you ever felt annoyed by criticism of your drinking? ___ No ___ Yes
- Have you ever felt guilty about your drinking? ___ No ___ Yes
- Have you ever taken a morning "eye-opener"? ___ No ___ Yes
- How much beer, wine, or hard liquor do you consume each week, on average?
- How much tobacco do you smoke or chew each day?
- Which drugs (not medications prescribed for you) have you used in the last 10 years & how frequently?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

Social:

Friendships, Community & Spirituality – describe quality, frequency, activities, etc:

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes and dreams?