Counseling Intake Form

The information requested in this form will be kept confidential.

DEMOGRAPHICS:

Last Name: _____ First Name: _____

Preferred Name: _____ Gender: ❑ Male ❑ Female ❑ Other

Date of Birth: ____/____/____ Age: _____

Home: _____ May I leave a message? ❑ Yes ❑ No

Cell: _____ May I leave a message? ❑ Yes ❑ No

E-mail: _____ May I email you? ❑ Yes ❑ No

Emergency Contact: _____ Phone: _____

Relationship to you: _____

Marital Status: ❑Married ❑Single ❑Separated ❑Divorced ❑Widowed

If applicable, Name of Significant other/Spouse:_____

How satisfied are you with your current relationship status? (Please circle)

Not Satisfied at all 1 2 3 4 5 6 7 8 9 10 Completely Satisfied

Please list any children/age/location:_____

_____

_____

_____

Turn for other side

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health? (Please circle)

Poor Average Good Excellent

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

_____

_____

_____

How would you rate your ability to manage your health conditions? (Please circle)

Poor Average Good Excellent

How would you rate your current sleep habits? (Please circle)

Poor Average Good Excellent

How would you describe your level of activity? (Please circle)

Poor Average Good Excellent

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

_____

_____

Have you previously participated in any type of mental health services (psychiatry, counseling, etc.)?

❑ No

❑ Yes, previous therapist/practitioner: _____

Have you ever been prescribed psychiatric medication? ❑No ❑Yes

Please list and provide estimated dates:_____

_____

_____

Are you experiencing overwhelming sadness, grief, or depression? ❑No ❑Yes

If yes, how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ❑No ❑Yes

If yes, when did you begin experiencing this? _____

Do you drink alcohol more than once a week? ❑No ❑Yes If yes, how often? _____

Do you currently use tobacco products ❑No ❑Yes

How often do you engage in recreational drug use? (Please circle)

Daily Weekly Monthly Infrequently Never

Please mark any of the following symptoms if you are experiencing or have experienced in the past.

Difficulty with:	**Now**	**Past**	**Difficulty with:**	**Now**	**Past**
Anxiety →			Finances →		
Depression			Legal Problems		
Mood Changes			Sexual Problems		
Anger or Temper			History of child abuse		
Panic			Domestic violence		
Fears			Abuse		
Irritability			Thoughts of harming yourself		
Concentration			Thoughts of harming others		
Headaches			Thoughts of suicide		
Loss of Memory			Sleeping too much		
Excessive Worry			Sleeping too little		
Feeling Manic			Getting to sleep		
Trusting Others			Waking too early		
Communicating with others			Nightmares		
Drugs			Head injury		
Alcohol			Nausea		
Caffeine			Chest Pain		
Frequent Vomiting			Lump in the throat		
Eating Problems			Heart palpitations		
Significant Weight Gain			Muscle tension		
Significant Weight Loss			Often make careless mistakes		
People in General			Restless/fidgety		
Relatives			Completing tasks		
Children			Paying attention		
Marriage/Partnership			Cluttered home environment		
Friend(s)					
Other acquaintances					
Managing medications					

Family Mental Health History:

Turn for other side

In the section below, identify if there is a family history of any of the following.
If yes, please indicate your relationship to the family member in the space provided (father, uncle, grandparent, sibling, etc.)

History of:	Yes	No	Relationship
Alcohol/Substance Abuse			
Anxiety			
Depression			
Bipolar			
Domestic Violence			
Sexual Abuse			
Suicide/Suicide Attempt			
Eating Disorders			
Obsessive Compulsive Behavior			
Hoarding			
Schizophrenia			

COUNSELING CONCERNS:

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

Please describe the concerns that bring you to counseling at this time:

Please share what you hope to accomplish or gain through counseling: