Intake Form

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Please provide the following information for your records. ***Leave blank any questions you would rather not answer in print.*** *Information you provide here is held to the same standards of confidentiality as in your counseling sessions.*

Name:_____
(Last) *(First)* *(Middle Initial)*

Name: _____
(Parent/guardian name if client is a minor)

Birth Date: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: ____ Ages: _____

Local Address: _____
(Street)

_____
(City) (State) (Zip Code)

Home Phone: _____
(Okay to leave a message?)

Cell Phone: _____
(Okay to leave a message?)

Work Phone: _____
(Okay to leave a message?)

Email: _____
(Okay to communicate through your email address?)

Referred by: _____

Is it okay to thank them for the referral? _____

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

If yes, was it helpful? _____

Are you currently taking prescribed psychotropic medications? ☐ Yes ☐ No

If yes, please list medications: _____

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)

_____

_____

3. Are you having any problems with your sleep habits? ☐ Yes ☐ No
If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor sleep quality
☐ Disturbing dreams ☐ Difficulty falling asleep ☐ Difficulty staying asleep

4. Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced significant weight change in the last 2 months? ☐ Yes ☐ No

5. Do you regularly use alcohol? ☐ Yes ☐ No

In a typical month, how often do you have 4 or more drinks in a 24-hour? _____

6. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

7. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

8. Are you currently in a romantic relationship? ☐ Yes ☐ No

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how do you rate the quality of your current relationship? _____

9. In the last year, have you experienced any significant life changes or stressors? ☐ Yes ☐ No

If yes, please list: _____

_____

			(0= none 10=high)
Have you ever experienced?	**Past**	**Last 3 months**	**Scale 0-10 if present now**
Extreme depressed mood	yes/no	yes/no	_____
Wild mood swings	yes/no	yes/no	_____
Rapid speech	yes/no	yes/no	_____
Extreme anxiety	yes/no	yes/no	_____
Panic attacks	yes/no	yes/no	_____
Phobias	yes/no	yes/no	_____
Sleep disturbances	yes/no	yes/no	_____
Hallucinations	yes/no	yes/no	_____
Unexplained losses	yes/no	yes/no	_____
Unexplained memory lapses	yes/no	yes/no	_____

	Past	Last 3 months	(if present now) Scale 0-10
Alcohol or substance abuse	yes/no	yes/no	_____
Frequent body complaints	yes/no	yes/no	_____
Eating disorder	yes/no	yes/no	_____
Body image problems	yes/no	yes/no	_____
Repetitive thoughts (e.g. obsessions)	yes/no	yes/no	_____
Repetitive behavior (e.g. frequent checking/hand washing)	yes/no	yes/no	_____
Homicidal Thoughts	yes/no	yes/no	_____
Suicide attempt	yes/no	yes/no	_____

Family History (Family of Origin):

Relative	Name	Current or age at	Illness or cau death	Education	Occupation	How would you descr relationship?

Relationships in the Family of Origin (your family history): Please describe:

Your parents' relationship with each other:

_____

_____

Please choose three adjectives to describe your mother(s) as you were growing up:

_____

_____

Please choose three adjectives to describe your father(s) as you were growing up:

_____

_____

Other significant adults (step parents, grandparents) in your life?

_____

_____

Please describe your parents' physical health problems, chemical use and or mental/emotional difficulties:

_____

_____

Please describe your relationship with you brothers and/or sisters in the past and present:

_____

_____

How would you describe your childhood?

_____

_____

OTHER INFORMATION

What are you current sources of relaxation and play?

_____

What are your goals for counseling?

_____

How will you know you are done with counseling?

_____

Thank you for taking the time to fill out this intake form.