**COUNSELING INTAKE FORM**

Please answer the following questions to the best of your ability. The information provided is held to the same standards of confidentiality as our therapy sessions.

**Contact Information**

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Gender: (check one) Male £ Female £ Transgender £ Non-Binary £

Marital status: (check one) Never married £ Partnered £ Married £ Separated £ Divorced £ Widowed £

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If needed, are we allowed to leave a voicemail or a message? Yes £ No £  
  
Cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If needed, are we allowed to leave a voicemail or text you? Yes £ No £

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If needed, are we allowed to send an email to this address? Yes £ No £

**Employment Information**

Are you currently employed? Yes £ No £

If yes, who is your current employer?   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your job position?   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy in your current position? Yes £ No £

Does your work make you feel stressed? Yes £ No £

If yes, what is stressing you at work? What are the work-related stressors?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Who can we contact in case of an emergency?

First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with emergency contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information**

Who were you referred by? (check one)

Insurance provider £ Internet search £ Advertisement £ Word of mouth £   
  
Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Primary insurance provider & identification number:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance subscriber name and date of birth:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary insurance identification number:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance subscriber name and date of birth:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health Information & Medical Health History**

Provide the name, address and telephone number for your primary care physician:   
  
  
First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
  
Primary Care Physician Address:   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your physical health at the present time?   
  
Poor £  
Unsatisfactory £   
Satisfactory £   
Good £   
Very good £  
Excellent £  
  
Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any persistent physical symptoms or health concerns (i.e., chronic pain, headaches, diabetes, thyroid dysfunction, hypertension, etc.):   
  
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Are you on any medication for your physical and/or medical issues? Yes £ No £

If yes, please disclose any medication you’re currently taking including dosage and frequency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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Are you having any problems with your sleep? Yes £ No £

Mark those that apply:

Sleep too little £ Sleep too much £ Poor sleep quality £ Disturbing dreams and nightmares £

Having trouble falling asleep £ Having trouble waking up £

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any changes or are you experiencing any difficulties with your eating habits?

Yes £ No £

If yes, mark those that apply:

Eating more £ Eating less £ Bingeing £ Restricting £ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced weight change (rise or drop) in the last two months? Yes £ No £

Do you exercise regularly? Yes £ No £

If you exercise, how many days per week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
How many minutes or hours per session do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consume alcohol regularly? Yes £ No £

In one month, how many times do you have four or more drinks in a 24-hour period?

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How often do you engage in recreational drug use?

Daily £ Weekly £ Monthly £ Rarely £ Never £

What kinds of recreational drugs do you use? Please list any recreational drugs that you use:  
  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in a romantic relationship? Yes £ No £

If you’re currently in a relationship, how long have you been in this relationship?  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale from 1-10 (10 being the best), how would you rate the quality of your current romantic relationship?   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last year, have you had any major life changes (i.e., new job, relationship change, moving, illness, death in the family, etc.)? Please disclose below:  
  
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Are you currently receiving any psychological services, professional counseling, psychiatric services, or any other mental health services?

Yes £ No £

Are you currently taking any psychiatric prescription medication? Yes £ No £

If yes, please disclose all medication you are taking, dosage, and frequency:  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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Have you been prescribed psychiatric prescription medication in the past? Yes £ No £

If yes, please disclose all medication you were taking in the past:  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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Have you been psychiatrically hospitalized in the past? Yes £ No £

If yes, please list dates, locations, and reasons of any previous hospitalizations:  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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**Quick Welfare Check Questionnaire**

Please mark any symptoms that you have experienced in the last month or are currently experiencing

£ Loss of interest in previously enjoyed activities

£ Withdrawing from other people

£ Spending increased time alone

£ Depressed  
£ OCD

£ Feeling numb

£ Rapid mood changes

£ Irritability

£ Anxiety

£ Panic attacks

£ Frequent feelings of guilt

£ Outburst(s) of anger

£ Avoiding people, places, or activities

£ Difficulty leaving your home

£ Fear of certain objects or situations

£ Worthlessness

£ Hopelessness

£ Sadness

£ Helplessness

£ Fear

£ Feeling or acting like a different person

£ Unusual sweating

£ Increased energy

£ Tremor

£ Frequent worry

£ Decreased energy

£ Dizziness

£ Physical sensations others don’t have

£ Intrusive memories

Describe in your own words any other symptoms or experiences you have had problems with that may not have been disclosed above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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**Family Mental Health History**

The following information you enter is about your family members. Please mark “Yes” if it applies and “No” if it does not apply.

If you mark “Yes”, kindly also provide name of that family member and indicate the relationship (i.e., Father, mother, brother, sister, uncle, cousin, aunt, etc.)

Depression Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Disorders Yes £ No £   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Panic Attacks Yes £ No £  
  
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Alcohol/Substance Abuse Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorder Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma History Yes £ No £   
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Abuse Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obsessive Compulsive Behavior Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia Yes £ No £  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

What do you like most about yourself? List your strengths below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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What are some areas you feel you need to develop?

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How are you coping with life obstacles and stress? Describe how you typically react to obstacles and stress:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
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What are your goals? What would you like to accomplish in therapy?

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Is there anything else you would like us to know about you?

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Signature: Intake Date:

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