

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 Informati	on		
First and Last Name:			
Date of Birth:/ Age:			
Gender: (check one) Male □ Female □ Transgender □	Non-Binary □		
Marital status: (check one) Never married \square Partnered \square Widowed \square	Married \square	Separated □	Divorced \square
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 □	





Employme	nt Infor
Are you currently employed? Yes □ N	o 🗆
If yes, who is your current employer?	
What is your job position?	
Are you happy in your current position? Yes \Box	No [
Does your work make you feel stressed? Yes \Box	No 🗆
If yes, what is stressing you at work? What are the	work-re
Emergency Co	ntact Ir
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 \Box Internet search \Box Advertisement \Box Word of mouth \Box
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, diabethyroid dysfunction, hypertension, etc.):	tes

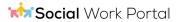


Are you on any medication for your physical and/or medical issues? Yes \square No \square
If yes, please disclose any medication you're currently taking including dosage and frequency:
Are you having any problems with your sleep? Yes \square No \square
Mark those that apply:
Sleep too little \square Sleep too much \square Poor sleep quality \square Disturbing dreams and nightmares \square
Having trouble falling asleep \square Having trouble waking up \square
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: Other:
Have you experienced weight change (rise or drop) in the last two months? Yes \square No \square
Do you exercise regularly? Yes \square No \square
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 \square No \square
In one month, how many times do you have four or more drinks in a 24-hour period?
How often do you engage in recreational drug use?
Daily \square Weekly \square Monthly \square Rarely \square Never \square
What kinds of recreational drugs do you use? Please list any recreational drugs that you use:
Are you currently in a romantic relationship? Yes \square No \square
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:





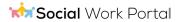
Are you currently receiving any psychological services, professional counseling, psyc any other mental health services?	hiatric services, c
Yes □ No □	
Are you currently taking any psychiatric prescription medication? Yes \Box	No □
If yes, please disclose all medication you are taking, dosage, and frequency:	
Have you been prescribed psychiatric prescription medication in the past? Yes \Box	No □
If yes, please disclose all medication you were taking in the past:	
Have you been psychiatrically hospitalized in the past? Yes \Box	No □
If yes, please list dates, locations, and reasons of any previous hospitalizations:	



Quick Welfare Check Questionnaire

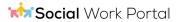
Please mark any symptoms that you have experienced in the last month or are currently experiencing

	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
П	Intrusive memories





Describe in your own words a not have been disclosed above		or experiences	you have had problems with that may
	Family Men	tal Health His	tory
The following information you "No" if it does not apply.	ı enter is about you	r family membe	rs. Please mark "Yes" if it applies and
If you mark "Yes", kindly also Father, mother, brother, siste			er and indicate the relationship (i.e.,
Depression	Yes □	No 🗆	
Suicide	Yes □	No 🗆	
Anxiety Disorders	Yes □	No □	_
Bipolar Disorder	Yes □	No 🗆	_
			_



Panic Attacks	Yes □	No 🗆
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: What are some areas you feel you need to develop? How are you coping with life obstacles and stress? Describe how you typically react to obstacles and stress: What are your goals? What would you like to accomplish in therapy?





Is there anything else you would like us to know about	vou?
is there anything else you would like us to know usout	, ou.
Signature:	Intake Date:
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