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.):

_____

_____

_____

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:

_____

_____

_____

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?

_____

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:

_____

_____

_____

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:

_____

_____

_____

Have you been prescribed psychiatric prescription medication in the past? Yes ☐ No ☐

If yes, please disclose all medication you were taking in the past:

_____

_____

_____

Have you been psychiatrically hospitalized in the past? Yes ☐ 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
- ☐ Intrusive memories

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

_____

_____

_____

_____

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 ☐

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 you?

_____

_____

_____

_____

Signature:

_____

Intake Date:

_____