INTAKE FORM

First Name/Last Name:

Parent Name(If Applicable):

Address:

Email:

Phone Number:

May we leave you a voicemail:

May we send you text message and email appointment

Date of Birth

Pronoun (she/her/hers. he/him/his. they/them/their

Insurance carrier/IDnumber/Groupnumber

How did you hear about us?

Spouse First Name

Reason for seeking counseling

First goal for therapy

Second goal for therapy

Third goal for therapy

List previous counseling with Counselor name, Year

Current employment and do you like it

Marriages/Relationships and how is it going curren

0 / 100

Education

• Names/ages of children and any information about

0 / 100

Siblings and relationship with each

0 / 100

Parents names/ Marital Status/If divorced, how old

Current Living Situation

Financial Concerns

Interests/Hobbies

Significant Life Events Examples: Serious illness

Any physical, sexual, or emotional abuse?

0 / 100

Medications (list name and dose)

Ever have a head injury as child or adult

felt you should cut down on drinking or drug use

Felt annoyed by criticism of your chemical use

Ever felt bad or guilty about chemical use?

any issues with substance besides alcohol

What role does spirituality play in your life?

Any Current or past Thoughts of Suicide? Yes No

General medical condition: Good Fair Poor

Family History of Mental Health Issues

Emergency Contact name and phone number

Select the symptoms that you experience:

- [ ] aggresion
- [ ] Alcohol dependence
- [ ] anger
- [ ] anti-social behavior

- [ ] anxiety
- [ ] avoiding people
- [ ] chest pain
- [ ] internet addiction
- [ ] sexual addiction
- [ ] depression
- [ ] disorganization
- [ ] disorganized thinking
- [ ] distractibility
- [ ] dizziness
- [ ] drug dependence
- [ ] eating disorder
- [ ] mood shifts
- [ ] fatigue
- [ ] gambling
- [ ] hallucinations
- [ ] high blood pressure
- [ ] hopelessness
- [ ] loneliness
- [ ] impulsivity
- [ ] irritability
- [ ] judgement errors
- [ ] memory issues
- [ ] panic attacks
- [ ] phobias
- [ ] reoccurring thoughts
- [ ] intrusive thoughts

- [ ] sexual difficulties
- [ ] sleeping problems
- [ ] suicidal thoughts
- [ ] withdrawing
- [ ] worrying

How have these symptoms effected your functioning?

Are there any unusual or special issues?

Are you involved in any legal issues?

Any drug or food allergies or adverse reactions?

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