INTAKE FORM

Name _____ Today's Date _____
Address _____ City _____ Zip _____
Phone: _____ E-mail address: _____
Age _____ Birth Date _____ Place of Birth _____
Church/Religion _____ Race/Ethnicity _____
Employer _____ Occupation _____
How did you hear about us? _____ May we thank that person? _____
Emergency Contact _____
Name Relationship Phone Number

Reason you are seeking counseling today _____
_____
_____
_____

Marital Status (please check one, and fill in detail if applicable)
Single_____ **Living with Significant Other** _____ How long together _____
Engaged _____ Wedding date _____ How long together _____
Married _____ Years married _____ Number of previous marriages _____
Separated _____ How long _____ **Divorced** _____ How long _____
Widowed _____ How long _____
Name of spouse or significant other _____
Describe your relationship _____
_____
_____

Children (if more than four please list on back of page)

Name	Relationship	Age	Sex	Living at home?

Who has legal custody of your children? _____

Describe what it is like to live in your household today. _____
_____
_____
_____

Describe your family and household when you were growing up._____

Are there any current addictions or history of addictions in you or immediate/extended family members (drugs, alcohol, sex, gambling, eating, pornography, prescription drugs, work, etc.)? _____
Who, how long, and what addiction? _____

Is there any mental illness currently or historically in you or your immediate/extended family members? Who, and what mental illness? _____

Have you ever experienced or witnessed physical, emotional, sexual abuse, or a violent crime? If yes, please explain:_____

Previous participation in counseling? Y/N When _____ With Whom _____
What was the focus of your treatment? _____

Have you **ever** taken medication for a mental/emotional condition? Y/N_____ If yes, complete the following:

Medication Name	Prescribed For	When Prescribed	How Long

Please list **all** other medications you are taking **currently** and what they are for. _____

Previous hospitalization for mental/emotional problems? Y/N___ When_____ How long _____
Have you ever thought about killing yourself or attempted suicide? Y/N___If yes, when_____
Please explain:_____

Describe any other significant or traumatic life experience. _____

If you have ever been diagnosed with a serious illness, please describe. _____

If you have any medical conditions that may affect your mental health treatment, please describe.

_____

If you are experiencing any medical/physical symptoms that you attribute to a mental/emotional/stress related condition, please describe. _____

_____

Describe your overall health today._____
Physical activity you participate in. _____

Symptoms or Concerns

Check all that apply:

- ☐ Feeling out of control
- ☐ Self-hatred
- ☐ Suicide attempts
- ☐ Hopeless
- ☐ Tearfulness
- ☐ Indecision
- ☐ Weight change
- ☐ Anxiety/nervousness
- ☐ Obsessive thoughts
- ☐ Stealing
- ☐ Impulsiveness
- ☐ Feelings of isolation
- ☐ Procrastination
- ☐ Grief
- ☐ Physical problems
- ☐ Hallucinations
- ☐ Hearing voices
- ☐ Recent loss
- ☐ Legal problems
- ☐ Menopause problems
- ☐ Learning problems
- ☐ Thoughts of dying
- ☐ Poor concentration
- ☐ Thoughts about suicide
- ☐ Agitation
- ☐ Mood changes
- ☐ Fatigue/tiredness
- ☐ Overwhelmed
- ☐ Angry outbursts
- ☐ Panic Attacks
- ☐ Hostility/rages
- ☐ Gambling
- ☐ Pornography
- ☐ Shyness
- ☐ Insecurity
- ☐ Sexual Problems
- ☐ Disruptive/conduct
- ☐ Dissociative episodes
- ☐ Bothersome memories
- ☐ Interpersonal conflicts
- ☐ Work problems
- ☐ School problem
- ☐ Lack of Motivation
- ☐ Guilt
- ☐ Slowed down
- ☐ Isolation/withdrawal
- ☐ Thoughts about hurting myself
- ☐ Fearful
- ☐ Sadness
- ☐ Emptiness
- ☐ Insomnia/oversleeping
- ☐ Overeating/Loss of appetite
- ☐ Irritability
- ☐ Loss of control
- ☐ Alcohol/drug addiction
- ☐ Sexual addiction
- ☐ Feelings of inferiority
- ☐ Feelings of failure
- ☐ Money problems
- ☐ Inappropriate speech
- ☐ Someone is trying to hurt me
- ☐ Recent crisis
- ☐ Domestic violence
- ☐ Family problems
- ☐ Social problems
- ☐ Worthlessness
- ☐ Restless/Keyed up

Any other important symptoms or concerns for your therapist to know:_____

_____

_____

_____