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INTAKE FORM

(Please complete a separate form for each person coming to counseling)

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Email Address _____

Address _____ Phone: _____

May I call you there? _____ May I leave a voice mail? _____ May I text you at this number? _____

Occupation _____ Phone: _____

Emergency Contact _____ Phone: _____
(Name and Relationship)

Status (circle all that apply): Single Dating Engaged Married Remarried Separated Divorced Widowed
Cohabiting

Partner's Name: _____ Occupation _____ Spouse's Age: _____

Persons living with you:

Name	Age	Relationship	Where do they live?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your partner or other family member ever been physically violent toward you? Yes No

Religious Preference: _____ Do you attend regularly: _____ Where: _____

Have you been in counseling previously? YES NO

If so, please provide the name of the counselor you saw: _____

Are you currently in counseling? YES NO

If so, please provide the name and location of the counselor: _____

If you answered yes to either of the previous questions, please answer the following:

a. How long have you been in counseling? Years _____ Months _____

b. How many counselors have you seen? _____

c. Was counseling for the treatment of the current problem? YES NO

Were you referred here? YES NO If yes, by whom: _____

How did you hear about this Clinic? _____

Are you on any type medication? YES NO

If yes, what medication: _____

Briefly describe your current physical health and any health problems currently being treated:

Who is your physician? _____

Previous major illnesses or major hospitalizations: _____

Current or Past History with Alcohol and/or Drug Abuse (Please Explain):

Please indicate with a check mark any of the following issues that are a concern for you at this time or have been a concern in the past. Please rank the three [3] **most important** concerns from 1, 2, 3 with 1 being the most urgent.

- | | | |
|--|--|---|
| <input type="checkbox"/> Career concerns | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Academic concerns | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Parent difficulty |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Child sexual abuse | <input type="checkbox"/> Suicidal thoughts/behavior |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Sexual assault | <input type="checkbox"/> Homicidal thoughts/behavior |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Anger control |
| <input type="checkbox"/> Sleeping difficulty | <input type="checkbox"/> Sexual orientation concerns | <input type="checkbox"/> Violent behavior |
| <input type="checkbox"/> Eating difficulty | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Other drug abuse | <input type="checkbox"/> Excessive fears |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Social concerns | <input type="checkbox"/> Obsessive thoughts/behavior |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Culture related issues | <input type="checkbox"/> Compulsive thoughts/behavior |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Dependency | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Self Injury | <input type="checkbox"/> Homesick | <input type="checkbox"/> Pornography |

Brief statement of concern (Why are you seeking counseling? What would you like to see different in your life as a result of counseling?) _____

Is there any additional information you feel would help me better understand your needs? _____

Signature

Date