Intake Form

Name:____ Date:____________

Address:____ DOB:____________

City:____________________________________ Zip:___________________________

Home Phone: ________________________ Work Phone:_______________________

Cell Phone: _________________________ Employer: _________________________

Married ____ Single ____ Divorced ____ Widow/er ____

In Case of Emergency Call: ____

Relationship: ________________________________ Phone: ____________________

Referred by: ____

Insurance Billing: _________ Yes ___________ No

____

Signature Date

____

Office Use

____

Therapist Date

1. Describe what is motivating you to pursue counseling at this time:

2. Describe your goals you wish to pursue in counseling:

3. What do you feel your most significant challenges are to achieve your stated goals?

4. What has your past experience been with counseling?

5. Describe what you see to be your strengths and weaknesses?

Medical History:

I am currently experiencing the following symptoms: (Please Check all that apply)

___ Depression
___ Weight gain
___ Weight loss
___ Worrying
___ Aggression
___ Suicidal thoughts
___ Suicidal attempts
___ Sleeping problems
___ Excessive crying
___ Poor concentration
___ Forgetfulness
___ Low energy
___ Withdrawal
___ Feelings of inadequacy
___ Delusions
___ Severe Headaches
___ Stomachaches
___ Fears
___ Irritability
___ Anger
___ Persistent guilt
___ Perfectionism
___ Eating disorders
___ Intense anxiety
___ Substance abuse
___ Panic attacks
___ Obsessions
___ Compulsions
___ Hallucinations
___ Chronic pain
___ Other: describe____

Briefly describe how the above symptoms impair your ability to function effectively:

Are you presently under a doctor's care? ___ Yes ___ No
Name of doctor: ____ Phone: __________

List the name and dosage of medications that you are presently taking:

When was your last thorough physical examination? ______________________________
Have you ever been hospitalized for a physical or emotional condition? ___ Yes ___ No
If so, when and where?____
Have you ever engaged in regular or frequent use of alcohol or drugs? ___ Yes ___ No
If so, describe quantity and frequency;
____
____

For women only: Do you ever experience premenstrual mood changes? ___ Yes ___ No
If so, please explain:
____
____