INTAKE FORM FOR INDIVIDUALS

Please print out this form, fill it out and bring it to your first session.
All the information you provide here is confidential.

Please print:
Name: _____ Date: _____
Age: _____ DOB_____ Male / Female Email: _____
Street Address: _____
City_____ State _____ Zip _____
Phone: Circle preferred phone: (Home) _____ (Work) _____ (Cell) _____
Is it okay to leave messages on your home telephone message device? Yes ( ) No ( )
Is it okay to text message you? Yes ( ) No ( )

Relationship information:
Marital Status: ___Married ___Coupled ___Single ___Divorced ___Separated __Widowed
Spouse's name _____ Date of marriage: _____
Have you ever been separated? _____ How long? _____
Have either of you ever filed for divorce? _____ When? _____
Number of children _____ Their ages: _____

Previous Marriages:
1. Year married: _____ How long: _____ Divorced ( ) Widowed ( )
2. Year married: _____ How long: _____ Divorced ( ) Widowed ( )
3. Year married: _____ How long: _____ Divorced ( ) Widowed ( )

Employment Information:
Are you currently employed? Yes( ) No( )
If Yes:
Occupation: _____ Employer: _____
How long at present job: _____ Annual household income (optional):_____
Education: _____
Do you enjoy your work? Yes( ) No( )

Faith background:
Do you consider yourself to be spiritual or religious? Yes ( ) No ( )
Do you identify as: Christian ( ) None ( ) Other_____
Please describe the importance of your faith or belief to you:_____
_____

Counseling Information:
Who referred you to the counselor? _____
Have any members of your family been here for counseling? Yes ( ) No ( )
Have you ever been to counseling, psychotherapy, or seen a psychiatrist? Yes ( ) No ( )
When? _____ Name of therapist: _____
Are you currently taking medication? Yes ( ) No ( )
Type: _____
Prescribed for what purpose: _____

Person we can call in case of an emergency:

Name: _____ Relation: _____

Address: _____ Phone: _____

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The following questions will help me to get a better idea about your concerns and background which will help me to serve you better in establishing your goals and developing a counseling plan.

1. Please describe your reasons for seeking counseling: _____

_____

_____

_____

2. What are you hoping to achieve as a result of counseling: _____

_____

_____

_____

3. Have there been any significant changes or stressful events in your life recently? If yes, when?

_____

_____

4. Have you ever hurt yourself or attempted suicide? Yes( ) No ( ) If yes explain:

_____

5. Are you currently having any thoughts of hurting yourself or others? Yes( ) No ( ) If yes explain:

_____

6. Do you drink alcohol more than once a week? No( ) Yes( )

7. Do you use recreational drugs? If yes, how often? Daily( ) Weekly( ) Once in a while( ) Never( )

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor -- Unsatisfactory -- Satisfactory -- Good -- Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor -- Unsatisfactory -- Satisfactory -- Good -- Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns. _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? No( ) Yes ( )
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? No( ) Yes( )
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? No( ) Yes( )
If yes, please describe? _____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety/Panic Attacks	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Or Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:
1. What do you consider to be some of your strengths?
_____
_____
_____
_____
2. What do you consider to be some of your weaknesses?
_____
_____
_____
_____
3. Any additional information you would like me to be aware of.
_____
_____
_____
_____
_____