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Confidential Intake Form

Date ____________

Personal Information

Name: ____

Date of Birth: ______________________ Age: ______ Gender: ______________

Street Address: ____

City, State, Zip: ____

Home Phone: ______________________ OK to call this number? Y / N OK to leave a message? Y / N

Cell Phone: ______________________ OK to call this number? Y / N OK to leave a message? Y / N

Email Address: ____________________________________ OK to contact you via email? Y / N

Employer and Occupation: ____

Work Phone: ______________________ OK to call this number? Y / N OK to leave a message? Y / N

Relationship Status:

__ Single __ Married __ Partnered __ Separated __ Divorced __ Widowed

Who are the members of your household? Please provide name, age, gender, and relationship.

____

____

Do you have any children who do not live with you? Please provide name, age, gender.

____

____

How did you find out about my services? ____

Is it OK to thank them for your referral? Y / N

Mental Health Information

Have you had counseling or therapy before? Y / N If yes, please describe briefly, including the reason, the name of the therapist, approximate dates, and whether the counseling was helpful.

Please list any medication or supplements you are taking for your mental health, including the prescriber's name.

What prompted you to seek counseling now?

Please check any of the following that are issues for you:

	Insomnia		Career Issues		Repetitive thoughts
	Depressed Mood		Relationship Issues		Repetitive behaviors
	Mood Swings		Work Stress		Cutting/self-mutilation
	Anxiety		Financial Issues		Suicidal thoughts or attempt
	Panic Attacks		Sexual Issues		Urges to harm others
	Phobias		Sexual or gender identity Issues		Hallucinations
	Anger issues		Spiritual or religious issues		Unexplained memory lapse
	Eating Disorder		Self-esteem issues		Grief or Loss
	Drug or Alcohol Abuse		Body image issues		Physical health issues

What goals do you have for yourself in counseling?

Health Information

Please describe any ongoing physical symptoms or health concerns (e.g., headaches, chronic pain, hypertension, diabetes, etc):

____

____

Name of Physician: ____ Phone ____________________

Please list any prescribed medications you are currently taking:

____

____

How often do you drink alcohol? ____

Do you use recreational drugs (e.g., pot, cocaine, ecstasy, etc.)? Y / N

If so, what do you use, how much, and how often?

____

____

Emergency Contact

In case of emergency, please contact:

Name: ______________________________________ Relationship: ______________________________

Address ____

Cell Phone __________________ Home Phone __________________ Work Phone __________________

Name: ______________________________________ Relationship: ______________________________

Address ____

Cell Phone __________________ Home Phone __________________ Work Phone __________________

Client Signature: ____ Date____________