COUNSELING INTAKE FORM

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Please complete the information requested based on the person who will be receiving counseling and answer the questions below. Please fill out this form and email it back to me before your first video session. Disclaimer: Your therapist will take reasonable efforts to protect your information however email/video are not 100% protected.

Client: □ Adult □ Child □ Couple □ Family
Intake Date: _____

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age:** _____ **Gender:** _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Race/Ethnicity:
□ African American □ Asian □ Caucasian □ Hispanic/Latino □ Bi- or Multiracial □ Native American □ Other:
_____
Please list any children/age: _____
Address: _____ (Street and Number)
_____ (City) (State) (Zip)
Home Phone: (_____) _____ - _____ **May I leave a message?** □ Yes □ No
Cell/Other Phone: (_____) _____ - _____ **May I leave a message?** □ Yes □ No
E-mail: _____

May we email you? □ Yes □ No
Please note: Email correspondence is not considered to be a confidential medium of communication.

What is the preferred way that I contact you: □ Home Phone □ Cell/Other Phone □ E-Mail

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ No
□ Yes, please list: _____
_____

Have you ever been prescribed psychiatric medication?
□ No
□ Yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?
□ 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?
□ 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, for approximately how long? _____

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

7. Are you currently experiencing any chronic pain?
□ No
□ Yes, please describe _____

8. Do you drink alcohol more than once a week?
□ No
□ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?

□ No
□ Yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

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 Select List Family Member

Alcohol/Substance Abuse: □ Yes □ No _____
Anxiety: □ 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 Attempts: □ Yes □ No _____

ADDITIONAL INFORMATION:

1. Are you currently employed?

□ No

□ Yes, what is your current employment situation? _____ Do you enjoy your work? Is there anything stressful about your current work?

_____

2. Do you consider yourself to be spiritual or religious?

□ No

□ Yes, describe your faith or belief? _____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses ?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____ _____

Signature of the person completing the form Print Name