Counseling Intake Form

Please fill in the following information. Give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Date _____

Your name _____**Age**____

Spouse's name _____**Age**____

Children's names _____ **Age**____

_____ **Age**____

_____ **Age**____

_____ **Age**____

Street Address _____

City _____State_____ Zip Code _____

Phone _____ Cell Phone _____

Email _____ Referral from _____

Is it OK to leave a message on an answering machine? (Circle answer)

At work? Yes No At home? Yes No

Is it OK to leave a message with a family member? Yes No

Permission to Text? Yes No

In case of emergency, whom may we contact? Name: _____

Emergency contact's phone # (other than your own home #) _____

Relationship to client: _____

Counseling History

Have you or your family ever received counseling for any reason? Yes ___ No ___

When? _____ what reason? _____

Reason for seeking counseling now:

_____

_____

_____

_____

How long have you been experiencing this difficulty?

_____

Are you presently working with any other Counselor or Psychiatrist? Yes ___ No___

What reason? _____ how long? _____

Counselor / Agency _____

Family History

Identify and describe your primary female caregiver (mother, relative, step mother) as you remember her during your life at home. List some of her characteristics as a person.

_____

_____

_____

Identify and describe your primary male caregiver (father, relative, step father) as you remember him during your life at home. List some of his characteristics as a person.

_____

_____

_____

How did your parents or caregivers get along with each other while you were in the home?

_____

_____

Describe any significant problems between you and your brothers and sisters:

_____

_____

_____

List any relatives with a history of emotional or mental disorder or suicide (include diagnosis and treatment if known)

_____

_____

_____

Relatives with a history of alcoholism or excessive alcohol or drug use:

_____

_____

List any significant past trauma experienced by you or those close to you (i.e., death, divorce, sickness, crime, etc.)

_____

_____

_____

Religious History

In what religious faith were you raised? _____

Present affiliation or name of church you attend? _____

Have you accepted Jesus as your Lord and Savior? Yes _____ No _____ Unsure _____

If yes, when did you accept Him? _____

Have your religious experiences and training helped or hurt your ability to deal with your struggles? _____

How often do you read your Bible? _____

Do you have a regular time to pray? _____

Have you had any unusual "religious experiences"? ____ Yes _____ No If yes, please explain:

_____

Check any losses that you have experienced:

__ Death of a Spouse __ suicide
__ Child __ miscarriage
__ Father __ abortion
__ Mother __ adoption
__ Sister __ infertility
__ Brother __ bankruptcy
__ Grandmother __ homelessness
__ Grandfather __ career or job loss
__ Aunt or uncle __ Divorce
__ Other _____

Check any concerns or issues you have now or in the past:

NOW - PAST
____ ____ Alcohol
____ ____ Academic issues
____ ____ Parent-child communication
____ ____ Attention deficient Hyperactivity disorder
____ ____ Peer pressure
____ ____ Suicidal thoughts __ suicidal attempt___ suicidal threat___
____ ____ Drugs _____
____ ____ Prescription Drugs _____
____ ____ binge eating, excessive dieting or exercise, purging
____ ____ shopping
____ ____ working too much
____ ____ procrastination
____ ____ communication
____ ____ depression
____ ____ anger / rage
____ ____ grief
____ ____ anxiety
____ ____ sexual abuse ___ Physical abuse ___ emotional abuse___ verbal ____
____ ____ gender identity

____ ____ sex
____ ____ pornography
____ ____ career
____ ____ loneliness
____ ____ mood swings
____ ____ low self esteem __ self hatred _____
____ ____ co – dependency
____ ____ stress
____ ____ fear _____
____ ____ negative or troubling feelings about church or God
____ ____ cutting or self injury
____ ____ addiction _____

General Information

MEDICAL:

Physician: _____City _____

Date last seen: _____ Reason _____

Ongoing medical concerns: _____

Allergies: _____

Medication(s) _____

LEGAL: Current _____ Previous _____ N/A _____

Charges _____ Probation? _____

Court district _____

EDUCATION:

Highest – grade achieved: _____

Name of College or Vocational school: _____

Year of Graduation _____ Graduate school _____

MILITARY:

Dates of service _____ Branch _____ Rank _____

Type of discharge _____

How were your relationships with peers? _____

With supervisors? _____

WORK HISTORY

Are you satisfied with your present occupation? _____

How long have you been with your present company? _____

Are you satisfied with your present income level? _____

DAILY ROUTINE

How is your appetite? _____ Any changes in the last six months? _____

Recent weight loss or gain? _____

How well do you sleep? _____Any changes in the last six months ____

Fall asleep OK? _____ Stay asleep? _____

Describe your exercise habits.

_____

_____

CLIENT CONSENT TO TREATMENT

I have read and received the Informed Consent and completed the Intake form.

_____ _____

Client # 1 Name (please print) Date

_____ _____

Client # 2 Name (please print) Date

_____ _____

Counselor Name/ Date

_____ _____