Your Safe Space, LLC

Standard Intake Form

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before? Yes No
If yes - Name of professional/Dates seen/Reasons for visit(s)/and detail your experience with the professional.

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol? Yes No
If yes, type/kind of alcohol, how much, and frequency

Do you use recreational drugs? Yes No
If yes, explain

Do you have suicidal thoughts? Yes No
If yes, please describe the suicidal thoughts.

Have you ever been hospitalized for a psychiatric issue? Yes No

Have you ever attempted suicide? Yes No

If yes, explain

Do you have thoughts or urges to harm others? Yes No

If yes, explain

Is there a history of mental illness in your family? Yes No

check all that apply

Depression Schizophrenia Bipolar Anxiety Delusions

(Dissociative Identity Disorder (DID) PTSD Eating Disorders Dementia

ADHD OCD Phobias Addictions (sex/substance/fetishes)

Other:_________________________________

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others, with family, etc..

What is your level of education? Highest grade/degree and type of diploma/degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

Increased appetite Decreased appetite Trouble concentrating Difficulty sleeping

Excessive sleep Low motivation Isolation from others Fatigue/low energy

Low self-esteem Depressed mood Tearful or crying spells Panic

Anxiety Fear Hopelessness Other____________

Please check any of the following that apply to client

Headache High blood pressure Gastris or esophagitis Hormone-related problems

Head injury Angina or chest pain Irritable bowel Chronic pain Seizures

Loss of consciousness Heart attack Heart Disease Bone or joint problems

Kidney-related issues Chronic fatigue Dizziness Faintness Diabetes

Heart valve problems Urinary tract problems Fibromyalgia Numbness & tingling

Shortness of breath Hepatitis Asthma Arthritis Thyroid issues HIV/AIDS

Cancer________ Other: __________________________

What else would you like me to know?____

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