THINK & LIVE WELL COUNSELING SERVICES

Dr. Rhonda Owens
Certified Counselor

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Intake Form (Adult)

Please provide the following information for my records. You are welcome to leave any questions unanswered if you choose not to respond. Rest assured, the details you share will be handled with the same confidentiality as our therapy or counseling sessions.

Name: _____
(Last) (First) (MI)

Today's Date ____/____/_____ Your Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female

Primary Address:

_____

(Street and Number)

_____

(City) _____ (State) _____ (Zip) _____

Home Phone: _____ May I leave a message? □Yes □No

Cell Phone: _____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No

Person to contact in case of an emergency:

_____ _____ _____
(Name) (Relationship to client) (Phone)

What prompted you to seek therapy/counseling or an assessment?

_____

_____

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Do you have children? □No □Yes

If yes, how many? _____ Ages: _____

Have you had previous counseling? □No □Yes

If yes,

Why? _____

Are you currently taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If yes, please list names and doses:

_____
_____

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never", when did you have these thoughts?

_____

_____

HEALTH INFORMATION

How is your physical health currently? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Date of last physical examination _____

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

_____

Any Allergies? □ No □ Yes If yes, please

List: _____

Medications: _____

Hours per night you normally sleep _____

Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ can't fall asleep □ can't stay asleep

Are you having any difficulty with your appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ eating less □ eating more □ Bingeing □ purging.

***Note: use rating scale with a "yes" response only.**

Are you now experiencing:			*Rating Scale 1-10 (10 =worst)
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Sleep Disturbances	yes	no	_____
Poor Concentration	yes	no	_____
Alcohol/Substance Abuse	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____
Eating Disorder	yes	no	_____
Physical Abuse	yes	no	_____
Emotional Abuse	yes	no	_____

Have you experienced this in the past:			*Rating Scale 1-10 (10 =worst)
Depressed Mood or Sadness	yes	no	_____
Irritability/Anger	yes	no	_____
Mood Swings	yes	no	_____
Racing Thoughts	yes	no	_____
Anxiety	yes	no	_____
Constant Worry	yes	no	_____
Panic Attacks	yes	no	_____
Phobias	yes	no	_____
Sleep Disturbances	yes	no	_____
Poor Concentration	yes	no	_____
Frequent Body Complaints (e.g., headaches)	yes	no	_____

OTHER INFORMATION:

What significance, if any, do religion and/or spirituality hold in your life?

_____

What do you consider to be your strengths?

_____

What is your favorite quality about yourself?

_____

What aspects of yourself do you find most challenging to accept?

_____

What are effective coping strategies you use when stressed?

_____

What are your overall goals for counseling?

_____

Is there anything that I did not ask about here that would be important for me to know about you?

_____

_____