**Power of Hope Counseling, LLC**

Jeanne Bielawa, MA, LPC, M.S. Ed. 412 Main Street, Danbury, CT 06810

Licensed Professional Counselor Phone Number: (203) 487-5963

Email: jb@powerofhopect.com FAX: (203) 730-8807

**ADULT CLIENT INTAKE FORM**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave a message? □ Yes □ No**

**E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I email you? □ Yes □ No**

***Please note: Email correspondence is NOT considered a confidential medium of communication and may be used for scheduling and other business purposes. Counseling IS NOT provided via e-mail or text.***

**Date of birth: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: □ Single □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed**

**Children/Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Emergency Contact (Name, Relationship to you, Current Phone Number)**

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**Are you currently employed? □ Yes □ No**

**What is your current or most recent job?**

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**Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and birth date of primary policy holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you previously received any type of mental health services (e.g., psychotherapy, psychiatric services?) If yes, please list the dates and type of services.**

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**Please list any prescription medications, that you are currently taking, and the reason for use:**

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**Have you ever been prescribed psychiatric medication? □ Yes □ No**

**Please list and provide dates:**

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**How would you rate your current physical health? (please circle)**

**Poor Fair Good Very Good Excellent**

**Please list any specific health problems you are currently experiencing:**

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**How often do you drink alcohol? □ Never □ Daily □ Weekly □ Monthly □ Infrequently**

**How often do you engage in drug use? □ Never □ Daily □ Weekly □ Monthly □ Infrequently**

**On a scale of 1-10 how has your alcohol and/or drug use impacted your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On a scale of 1-10 how has a family member’s alcohol and/or drug use affected your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you aware of any of the following in your family? Please Circle and List Family Member**

**Alcohol/Substance Abuse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Domestic Violence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eating Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bipolar Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Obsessive Compulsive Behavior \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Schizophrenia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Suicide or suicide attempts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PTSD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently involved in a romantic relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ On a scale of 1-10 how satisfied are you with this relationship? \_\_\_\_\_\_\_\_**

**What, if any, significant life changes or stressful events have you experienced recently?**

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**What would you like to accomplish in therapy? Is there any other information you would like me to know about you?**

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**Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**