Beth Daniel, M.A.
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INTAKE FORM

Please note the information in this form is confidential.

Legal Name:_______________________________________ Date: ___________________
Resident Address:____
Mobile:(_____)________-_________ Email:______________________@______________
DOB:____/______/______ Age:________ Gender:______________
Ethnic background (African American, Filipino, Irish, Caucasian, Hispanic, etc.):____________
____
List Religious Affiliation/Spiritual Involvement: ___________________________________
Church Name: ____
Rate how important spirituality is to you: (0 = no importance, 10 = great importance) _________
Employer: _______________________Occupation: _______________________ F/T or P/T?
Student: Y/N School:_____________________ Current Grade Level:___________________

Primary Physician: ______________________________ Phone: (_____)________-________
Current Rx and Dosage:____
Current Therapist: _______________________________ Phone: (_____)________-________
Emergency Contact: ______________________________ Phone: (_____)________-________
Referred by: _____________________________________

Have you **ever** used any of the following?

Caffeinated beverages	Y/N	Kind:___________	Amount:_________	Frequency:_________
Alcohol	Y/N	Kind:___________	Amount:_________	Frequency:_________
Tobacco	Y/N	Kind:___________	Amount:_________	Frequency:_________
Marijuana	Y/N	Kind:___________	Amount:_________	Frequency:_________
Hallucinogens (LSD)	Y/N	Kind:___________	Amount:_________	Frequency:_________
Heroin	Y/N	Kind:___________	Amount:_________	Frequency:_________
Methamphetamines	Y/N	Kind:___________	Amount:_________	Frequency:_________
Cocaine	Y/N	Kind:___________	Amount:_________	Frequency:_________
Stimulants (Pills)	Y/N	Kind:___________	Amount:_________	Frequency:_________
Ecstasy	Y/N	Kind:___________	Amount:_________	Frequency:_________
Methadone	Y/N	Kind:___________	Amount:_________	Frequency:_________
Tranquilizers	Y/N	Kind:___________	Amount:_________	Frequency:_________
Pain Killers	Y/N	Kind:___________	Amount:_________	Frequency:_________

Have you ever been abused?: Physically ____ Sexually _____ Verbally_____ Emotionally ____

FAMILY

Parent's Names:	Age:	Job/Retired:
______________________________	________	_______________________
______________________________	________	_______________________

Siblings:	Age:
_____________________________	_______
_____________________________	_______
_____________________________	_______
_____________________________	_______

Your Children:	Age:
_____________________________	_______
_____________________________	_______

Did your parents marry? Y/N Are your parents divorced? Y/N How old were you?______
Were you adopted? Y/N Who raised you? _______________________________________
Family member medical or psychological conditions: __________________________________

CHIEF COMPLAINT

Why did you come? ____
____
Complaint start date: ____/______/______
On a scale of 1-10, how important is this issue to you? (10 = of greatest importance) __________
Previous therapist(s) seen for Complaint: ____
Previous treatment for Complaint: ____

SYMPTOMS
(Check all that apply)

☐ Anxious	☐ Tearful	☐ Cutting	☐ Excessive Energy
☐ Suspicious	☐ Depressed	☐ Guilt	☐ Suicidal Thoughts
☐ Hear Voices	☐ Hallucinations	☐ Lonely	☐ Difficulty eating
☐ Fatigue	☐ Aggressive	☐ Loss of Interest	☐ Difficulty Sleeping

Anything else you would like the counselor to know?

____
____
____
____

I certify what I have written in the above form is correct to the best of my knowledge.

____ ____/_____/ 20____

Signature of client/guardian Date