COUNSELING INTAKE FORM

Name:	Date:
Date of Birth:	SSN: Gender: M / F / T
Home Phone:	Is it ok to leave a message/text you at this number? Y / N
Work Phone:	Is it ok to leave a message/text you at this number? Y / N
Mobile/Cell Phone:	Is it ok to leave a message/text you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address (where you receive mail):	
Physical Address:	

Insurance Company:	
Subscriber Name (if not you) :	
Subscriber DOB:	

Emergency Contact Name:	Relationship:
Emergency Contact phone number:	

How were you referred?	May I thank them? Yes____ No___
Doctor's Name:	**Address/phone:**
Psychiatrist Name:	Address/phone
Involved Community Support agencies (list)?	Address/phone:

Married?	Y / N	Spouse's Name:	
Children?	Y / N	First Names/Ages?:	
Employed?	Y / N	Where?	How long?
Parents living?	Y / N	Where?	
Military?	Y / N	Branch/years?	
Legal History?	Y / N	Reason/years?	
Allergies?	Y / N	Type?	

During the last month, have you often been bothered by feeling down, depressed or hopeless? Yes___ No___

During the past month, have you often been bothered by little pleasure or interest in doing things? Yes___ No___

How would you rate your anxiety today on a scale of 1-10 with 10 being HIGH anxiety? 1 2 3 4 5 6 7 8 9 10

How would you rate your mood today with 10 being the BEST MOOD ever? 1 2 3 4 5 6 7 8 9 10

Do you have any medical conditions or other concerns about your physical health? Please specify:

Any history of head injury or concussion where you lost consciousness? How long ago??

Please list medicines you are currently taking (with dose and prescriber), or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Have you ever been hospitalized for medical or mental health reasons? When, why, and for how long? _____

Do you get regular exercise? If so, what type and how often? _____

Do you have a spiritual or cultural practice or religious preference? What is it?_____

Do you use alcohol or other drugs recreationally such as marijuana, cocaine, overuse or prescription medications? Yes___ No___
Have you in the past? Yes___ No___

If yes, what did you use and how old were you when you started? _____

Longest period of sobriety?_____

Where were you born? Raised?

Where did you attend School?

Did you attend College or a trade school? Where and what did you study?

Hobbies/Special Interests (even if you are not doing them now):

What are your goals for coming to counseling?

How will know that you have reached your goals (what will be different?

Client Signature Date