Heartstrings Counseling
Healing Hearts, Healing Families

14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.618.1579 | FX 651.925.0415

INTAKE INFORMATION

Client name:_____ Date of birth:_____

Address:_____Phone #_____

City:_____ State:_____ Zip code:_____

Spouse/Partner: _____

Children: Name _____ Age _____
Name_____Age _____

Adult marital status: Single Married Divorced Widowed Separated

Form of Payment:

☐ **Insurance** ☐ **Self Pay**

Insurance: _____ **Individual ID # _____**

Group # _____ Phone Number: _____

Reason for seeking therapy at this time:
_____

Home phone: Ok to call? Yes No Cell phone:_____ Ok to call? Yes No

Work phone:_____ Ok to call? Yes No

Email: _____

Okay to discuss scheduling via email? Yes No

Okay to send statement or receipts per email? Yes No

Occupation:_____ Please circle: Full time Part time

Employer:_____

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Developmental:
How was the mother's overall health during pregnancy with this person?
_____

Which of the mother's pregnancy was this? (i.e. 1, 2, or 3)
_____

What substances, if any, did the mother use during the course or pregnancy (including before learning she was pregnant?

Alcohol: Describe amount and frequency _____
Tobacco: Describe amount and frequency _____
Street Drugs: Describe what drugs, amount, and frequency: _____
Prescription Drugs: Describe what drugs, amount, and frequency: _____

What supports were available to you as a parent during the pregnancy?

Cultural Influences:
_____
_____

Military
Does anyone in your family have military or combat experience? Yes _____ No_____
Where? _____

Length of Service? _____

Branch? _____

Type of discharge? _____

Effects on child and family? _____

Medical Info:
Name of Physician and/or clinic _____

Current Health Issues: _____

Medications _____ Dosage amount: _____ Prescribed by _____
_____ Dosage amount: _____ Prescribed by _____

PREVIOUS MENTAL HEALTH INTERVENTIONS
Psychiatrist: Name: _____ Location:_____
Hospitalizations: _____
Name of Therapist / Clinic _____
Dates of Services: _____
Name of Therapist / Clinic _____
Dates of Services: _____

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Was it helpful? _____

Family Psychiatric Concerns

_____
_____
_____

Child abuse: Physical abuse Yes/No **Sexual Abuse** Yes/No **Emotional Abuse** Yes/No

SUBSTANCE ABUSE:
Do you drink alcohol or use drugs? YES NO
If yes, what drugs are he/she currently using or has used in the past?

_____
_____

1. In the past 3 months, have you ever felt you should cut down, or stop drinking or use drugs?

2. In the last 3 months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or stop using drugs?

3. In the last 3 months, have you felt guilty or bad about how much you drink or use drugs?

4. In the last 3 months, have you woke up to have a drink to get rid of a hangover or steady your nerves?

Goals in Counseling **1.** _____
2._____
3._____

Risk Factors:
Self-Injury/Suicide: Yes/No If yes, when? _____

How did you learn of us?_____

Referred by:_____

Emergency Information

In case of emergency, contact:_____

Relationship:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____