INTAKE FORM

Date___________
Given/Birth Name:_________________________
Chosen Name____________________________
Date of Birth: ___________________________ Age: _________
Gender:_________________________
What Pronouns do you use? She/her He/Him They/Them
Other____________________
Address: ____
City: _____________________________________ Zip Code: _______________
Telephone: Home ( ) _____________________ Cell _____________________
Ok to leave a message? Yes______ No_________
Email Address: ____
Occupation:____
If you are a student, where do you go to school?____________________________
Type of payment: Self Pay___________ or insurance/EAP________________

How did you hear about my practice?____

Emergency Contact: Name____
Telephone: Home _____________________ Cell_________________
Relationship to you? _____________________________
Email:____

Relationship Status:
Single: ____ Partnered: ____ Married: ____ Divorced: _____ Other: _________
Do you identify as Gay______ Straight_________ Bisexual ______ Other______
Spouse/Significant other Name: _____________________________ Age:_______
Do you have any children?: Yes _____ No: _____
Name(s) & Ages (s):
____

Who lives in your house with you?____

Have you been in counseling/therapy before? Yes: _____ No: _____
If yes, with whom?
____
Name of previous counselor/therapist

Primary Care Physician:
____

Current medications & reason for taking (prescribed and over the counter)
____

____
____

Have you ever had a concussion(s)?
If Yes , Please give date and severity_____________________________________

Any mental health hospitalization? Yes: _____ No: ____
Name of Hospital:
____

Have you ever had any suicide attempts?
____
____

Alcohol and Drugs issues (Past & Present):
____
____
____

Family History of mental Illness, addiction
____
____
____

What significant life changes or stressful events have you experienced recently?
____
____
____

Reason(s) for seeking counseling/therapy:
____
____
____
____
____
____
____