

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:

