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INTAKE FORM

TODAY'S DATE: __/__/__ DOB:__/__/__
LAST NAME:_____FIRST NAME:_____MIDDLE INITIAL:_____

PRESENT MAILING ADDRESS:

_____
STREET CITY STATE ZIP CODE

Y/N Y/N

_____
HOME PHONE OK TO LEAVE MSG? CELL PHONE OK TO LEAVE MSG?

EMAIL ADDRESS: _____ **OK TO EMAIL YOU?** Y/N

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, NAME OF COMPANY:_____

YOUR RESIDENCE:
WHO LIVES IN YOUR HOME: _____
_____

ARE YOU EMPLOYED?: YES ☐ NO ☐ TYPE OF WORK:_____HOURS PER WEEK:_____

WHO REFERRED YOU TO COUNSELING (CHECK ALL THAT APPLY)?
☐SELF ☐EMPLOYER ☐FRIEND ☐PHYSICIAN ☐COURT ☐FAMILY
OTHER:_____

THERAPY IS BENEFITTED BY COUNSELORS' UNDERSTANDING OF CLIENTS' CULTURAL CONTEXTS.
RACIAL/CULTURAL/ETHNIC IDENTITY: _____
SEXUAL IDENTITY:_____
PRIMARY SPOKEN LANGUAGE: _____LANGUAGE SPOKEN AT HOME:_____

EDUCATIONAL INFORMATION:
☐ SOME HIGH SCHOOL ☐ COMPLETED HIGH SCHOOL ☐SOME COLLEGE
☐ COMPLETED BA/BS ☐SOME GRAD SCHOOL ☐ COMPLETED GRAD SCHOOL
OTHER:_____

Romantic Partner Status:

☐ Single/Non-Partnered. How long?_____
☐Dating. How long?_____
☐Significant Relationship. How long?_____
☐Married/Partnered. How long?_____
☐Divorced/divorce history. How long?_____
☐Separated. How long?_____
Additional information regarding significant relationships:_____

_____
_____
_____

Family History:

Age of Parents: Mother_____Father _____Who primarily raised you?_____
If your parent(s) is/are deceased, when? Mother_____Father_____
Parents' relationship status: ☐Married ☐Divorced ☐Separated ☐Other _____
When?_____
Do you have Children? Yes ☐ No ☐
If Yes, please list ages:_____
Has anyone in your family been hospitalized for psychological reasons?Yes ☐ No ☐
If yes, please explain: _____
Has anyone in your family had an alcohol or substance abuse problem? Yes ☐ No ☐
If yes, please explain:_____
Has anyone in your family had a mental health problem (e.g., depression, bipolar disorder, schizophrenia, etc.)? Yes ☐No ☐ If yes, please explain:_____

_____
_____

Medical and Mental Health History:

Do you have any medical conditions? Yes ☐ No ☐
Please specify: _____
Are you currently taking medications? Yes ☐ No ☐
Names of medications:_____
Who prescribed them for you?_____
Do you have a documented disability? Yes ☐ No ☐
If yes, please describe:_____

_____

Have you previously had counseling/psychotherapy? Yes ☐ No ☐
If yes, please specify when, why, and was it helpful?_____

_____
_____

Have you ever been hospitalized for mental health reasons? Yes ☐ No ☐
If yes, please describe:_____

_____

Have you seriously considered attempting suicide in the past? Yes ☐ No ☐
If yes, when?_____
Have you ever made a suicide attempt in the past? Yes ☐ No ☐
If yes, when?_____

Checklist of Personal Concerns			
I am concerned about:	No concern	Moderate Concern	Serious concern
Making or keeping friends	☐	☐	☐
Making or keeping a romantic partner	☐	☐	☐
Conflict with a romantic partner	☐	☐	☐
Difficulty with children	☐	☐	☐
Conflict with other family member(s)	☐	☐	☐
Conflict with friends/coworkers	☐	☐	☐
Trouble being open with others	☐	☐	☐
Trouble adjusting	☐	☐	☐
Sexuality and/or sexual identity	☐	☐	☐
Feeling lonely and/or not fitting in	☐	☐	☐
Religious or spiritual problem	☐	☐	☐
Trouble concentrating	☐	☐	☐
Trouble listening	☐	☐	☐
Trouble completing work on time	☐	☐	☐
Job performance difficulties	☐	☐	☐
Wasting time on the computer	☐	☐	☐
Concern about my career choice	☐	☐	☐
Getting angry easily	☐	☐	☐
Anxious in social situations	☐	☐	☐
Experiencing panic symptoms	☐	☐	☐
Unable to relax	☐	☐	☐
Obsessive, intrusive, or repetitive thoughts or behaviors	☐	☐	☐
Experiencing discrimination	☐	☐	☐
Legal problems	☐	☐	☐
Experiencing extreme mood swings	☐	☐	☐
Feeling down or unhappy	☐	☐	☐
Death or impending death of a significant person	☐	☐	☐
Upset about end of relationship	☐	☐	☐
Use of alcohol	☐	☐	☐
Use of illegal or prescription drugs	☐	☐	☐
Use of caffeine	☐	☐	☐
Use of tobacco	☐	☐	☐
Self-esteem	☐	☐	☐
Amount and quality of my sleep	☐	☐	☐
Eating habits	☐	☐	☐
Dissatisfied with my appearance	☐	☐	☐
Low energy/fatigue	☐	☐	☐
Financial problems	☐	☐	☐
Physical health	☐	☐	☐
Self-harm	☐	☐	☐
Suspicion or paranoid thoughts	☐	☐	☐
Hallucinations	☐	☐	☐
Recent crisis or trauma	☐	☐	☐
Past or current physical or sexual abuse	☐	☐	☐
Thinking about killing myself	☐	☐	☐
Thinking about harming someone	☐	☐	☐
Other concerns:_____			

Your primary reason for seeking counseling:_____

_____

_____

_____

_____

Current Level of Distress:

Please circle the number that best represents your current level of distress regarding your concerns:

Emotional Well-Being
Low 1 2 3 4 5 Severe

Occupational Performance/Satisfaction
Low 1 2 3 4 5 Severe

Social Relationships/Social Activities
Low 1 2 3 4 5 Severe

Daily Routine
Low 1 2 3 4 5 Severe

Please sign and date to indicate that you have answered the above questions fully and truthfully to the best of your ability:

Print name: _____

Client Signature: _____ Date:__/__/__