

INTAKE FORM (I)

Date _____

Personal Data:

Name _____ Age _____ DOB ____/____/____ SSN ____-____-____

Phone (home) _____ (work) _____ (cell) _____

Please star () by number(s) at which you are comfortable for a counselor to contact you.*

Address _____ ZIP _____

Occupation & Employer _____

Education — highest grade completed _____ Degree(s) and/or Certificates _____

Family Gross Annual Income \$ _____ Military Service _____

Marital Status (*check one*) never married engaged married separated divorced

Marriage history _____

Spouse/partner Data:

Name _____ Age _____ Home Church _____

Occupation & Employer _____

Family Data:

Names of Children/others living at home	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Special living/custody circumstances _____

Medical Information:

Date & reasons for last physical exam _____

Current medications (prescription or over-the-counter) _____

Allergies _____

History of serious accident or illness _____

Previous counseling experience (reasons & dates) _____

Reason(s) you are seeking counseling _____

Primary Physician _____ phone _____

Emergency contact person _____ phone _____

Referred by _____

Substance Use & History:

	Self		Spouse
tobacco (any form)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	tobacco (any form)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No
alcohol	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	alcohol	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No
caffeine (& cola)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	caffeine (& cola)	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No
recreational drugs	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No	recreational drugs	<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> No
type _____		type _____	

(1) Check any concerns you have. (2) Number the most important in order (#1 = most important, etc.).

Stressors:

<input type="checkbox"/> aggression	<input type="checkbox"/> finances	<input type="checkbox"/> problem-solving
<input type="checkbox"/> alcohol/drugs	<input type="checkbox"/> grief/loss	<input type="checkbox"/> relaxation
<input type="checkbox"/> anger	<input type="checkbox"/> guilt	<input type="checkbox"/> self-harm
<input type="checkbox"/> appetite	<input type="checkbox"/> helplessness	<input type="checkbox"/> sexual abuse
<input type="checkbox"/> authority	<input type="checkbox"/> impulse control	<input type="checkbox"/> sexual stress
<input type="checkbox"/> career	<input type="checkbox"/> indecision	<input type="checkbox"/> shyness
<input type="checkbox"/> communication	<input type="checkbox"/> in-laws	<input type="checkbox"/> sleeplessness
<input type="checkbox"/> compulsions	<input type="checkbox"/> irritability	<input type="checkbox"/> stress
<input type="checkbox"/> concentration	<input type="checkbox"/> legal matters	<input type="checkbox"/> suicide
<input type="checkbox"/> depression	<input type="checkbox"/> loneliness	<input type="checkbox"/> verbal abuse
<input type="checkbox"/> dreams	<input type="checkbox"/> marriage	<input type="checkbox"/> work
<input type="checkbox"/> energy	<input type="checkbox"/> nervousness	<input type="checkbox"/> worry
<input type="checkbox"/> faith	<input type="checkbox"/> parenting	<input type="checkbox"/> other _____
<input type="checkbox"/> fears	<input type="checkbox"/> physical abuse	<input type="checkbox"/> other _____

(This space reserved for additional comments by clinician)

Symptoms:

<input type="checkbox"/> back pain	<input type="checkbox"/> diarrhea	<input type="checkbox"/> muscle spasms
<input type="checkbox"/> chest pain	<input type="checkbox"/> touch aversion	<input type="checkbox"/> seizures
<input type="checkbox"/> rapid heartbeat	<input type="checkbox"/> fatigue	<input type="checkbox"/> sleeplessness
<input type="checkbox"/> dizziness	<input type="checkbox"/> flushes	<input type="checkbox"/> oversleeping
<input type="checkbox"/> nausea	<input type="checkbox"/> headaches	<input type="checkbox"/> disturbing thoughts
<input type="checkbox"/> numbness	<input type="checkbox"/> dry mouth	<input type="checkbox"/> tremors/shakes
<input type="checkbox"/> indigestion	<input type="checkbox"/> fainting	<input type="checkbox"/> tics/spasms
<input type="checkbox"/> skin problems	<input type="checkbox"/> sweating	<input type="checkbox"/> vision problems
<input type="checkbox"/> blackouts	<input type="checkbox"/> weight changes	<input type="checkbox"/> other _____
<input type="checkbox"/> constipation	<input type="checkbox"/> hearing problems	<input type="checkbox"/> other _____

(This space reserved for additional comments by clinician)

What do you feel are personal/family strengths, skills, and abilities which have helped you to cope so far?

Have you any goals or ideas in mind as to how counseling may help you?
