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Counseling Intake Form

This information is confidential. Please answer what you can and what you wish.

Demographic Information

Name: ____ Today's date: ____________________

Date of Birth: _____________________________________ Age: _______

Phone: _____________________________ May we leave a message at this number? Yes No

Email: ____ May we email you? Yes No

Address: ____

Emergency Contact Name: ____

Relationship: _____________________________________ Phone: _________________________

Chief Concern

Please describe the main difficulty that has brought you to see me:

____

____

____

____

____

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____

Your Medical Care

From whom or where do you get your medical care?

Clinic Name: ____

Phone: ____

Doctor's name: ____

Address: ____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed, and we can coordinate your treatment? Yes No

Your Current Employer

Employer: ____

Work phone: ____

Address: ____

Occupation: ____

Length of time with this employer: ______________________________

Please indicate any restrictions on calls: ___________________________

Present Relationships

How do you get along with your spouse or partner?

____
____
____
____
____
____

How do you get along with your spouse or partner?

____
____
____
____
____
____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

If yes: Please indicate type of treatment (select one): Inpatient Outpatient Both

When: ____

From whom: ____

For what: ____

Results: ____

____

Past Psychological/Psychiatric Treatment continued

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes: Please indicate type of treatment (select one): Inpatient Outpatient Both

When: ______________________________

From whom: ______________________________

For what: ______________________________

List of Symptoms

Please indicate if any of the following have been bothering you lately:

☐ abused as child	☐ confidence	☐ health problems	☐ panic attacks
☐ agoraphobia	☐ depression	☐ inferiority feelings	☐ phobias
☐ alcohol use	☐ divorce	☐ insomnia	☐ relationships
☐ ambition	☐ drug use/abuse	☐ loneliness	☐ sadness
☐ anger	☐ eating problem	☐ making decisions	☐ self-esteem
☐ anxiety	☐ education	☐ marriage	☐ separation
☐ appetite	energy: ☐ high ☐ low	☐ memory	☐ sexual problems
☐ being a parent	☐ extreme fatigue	☐ my thoughts	☐ short temper
☐ bowel trouble	☐ fears	☐ nervousness	☐ shyness
☐ career choices	☐ fetishes	☐ nightmares	☐ sleep
☐ children	☐ finances	☐ obsessive thinking	☐ stress
☐ compulsions	☐ friends	☐ health problems	☐ suicidal thoughts
☐ compulsivity	☐ guilt	☐ overweight	☐ work
☐ concentration	☐ headaches	☐ painful thoughts	

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not Applicable
Marriage/Relationship	1	2	3	4	5	6
Family	1	2	3	4	5	6
Job/School Performance	1	2	3	4	5	6
Friendships	1	2	3	4	5	6
Financial Situation	1	2	3	4	5	6
Physical Health	1	2	3	4	5	6
Anxiety Level/Nerves	1	2	3	4	5	6
Mood	1	2	3	4	5	6
Eating Habits	1	2	3	4	5	6
Sleeping Habits	1	2	3	4	5	6
Sexual Functioning	1	2	3	4	5	6
Alcohol/Drug Use	1	2	3	4	5	6
Ability to Concentrate	1	2	3	4	5	6
Ability to Control Anger	1	2	3	4	5	6

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?___________________________

How many days per week do you consume alcohol? _______________________________________

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe: ____

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.