Intake Information

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Date of Intake: _____

Name of Patient:	**Date of Birth:**
Address *(#, street, city, state, zip code)***:** _____	**Telephone no.:**
Email:	**Preferred method of contact? Phone__ Email ___**

May we leave a message? Yes _____ No _____

How did you find out about us? _____
Referral? _____ (Y/N) If yes, who referred you?
_____

Ethnicity/Race/Culture you identify with and consider yourself: _____

Reason(s) for making this appointment:_____

_____

_____

Medical History:_____

_____

Have you ever been hospitalized? If yes, please provide reasons for and details about your hospitalization:_____

_____

_____

When was your last physical examination? _____

Mental Health History (including past or current psychotherapy treatment):

_____

_____

Have you ever been admitted and stayed in a behavioral or psychiatric (mental health) treatment facility? If yes, please provide reasons and give details about your stay.

_____

_____

_____

Are you taking any medications? Yes ____ No____ Type(s): _____

_____

If yes, what is the dosage and frequency? _____

Are you a student? Yes_____ No _____

If yes, what institution?_____

Are you employed? Yes_____ No _____

If yes, name of employer or type of employment: _____

_____

How do you feel about your school?_____

How do you feel about your job? _____

Have you now or in the past self-harmed or threatened to self-harm? Yes_____ No_____

If yes, what did you do? _____

How frequently? _____

When did you last attempt to harm yourself? _____

Do you have now or in the past, suicidal thoughts? Yes _____ No_____

How frequently? _____

Have you attempted suicide? Yes _____ No_____ How many times? _____

Do you smoke? _____ If yes, how much/frequency?_____
Do you consume alcohol? _____ How much/frequency?_____

Do you participate in drug use?_____ What type(s)?_____
Frequency of drug use: _____

Do you exercise? _____ How many times per week?_____

How are your sleeping habits? Good ____ Fair ____ Poor ____ Explain: _____
_____

How are your eating habits? Good ____ Fair ____ Poor ____ Explain: _____
_____

What are your spiritual beliefs? _____
_____

Do you feel sadness or depression? _____

Do you feel angry? _____

Do you feel hopeless? _____

Describe your life and rank how satisfied or dissatisfied you are presently. (0 = very dissatisfied, 1 = moderately dissatisfied, 2 = mildly dissatisfied, 3 = somewhat satisfied, 4 = moderately satisfied, 5 = very satisfied)

Are you in a relationship with anyone? Yes ____ No____ If yes, for how long? _____

Describe most recent relationship: _____

Who lives in your household with you?

Name	Relationship to you	Age

What are your strengths? _____

What are your weaknesses? _____

What are your concerns? _____

What do you want to accomplish with counseling? Goals?

Past and/or Current Diagnoses:

_____

Family Mental Health History:

Type(s)	You	Family Member (Who?)
Anxiety		
Anger		
Autism Spectrum		
Depression		
Physical Abuse		
Sexual Abuse		
Suicide or Suicide attempts		
Other (describe)		

Have you experienced any trauma? What type(s)?_____

Emergency Contact Information #1

Name (Last, First, MI)	**Relationship to Client**
Address (Street or P.O. Box Number)	**(City, State, Zip Code)**
Telephone Number (xxx-xxx-xxxx)	**Email Address**

Emergency Contact Information #2

Name (Last, First, MI)	**Relationship to Client**
Address (Street or P.O. Box Number)	**(City, State, Zip Code)**
Telephone Number (xxx-xxx-xxxx)	**Email Address**