COUNSELING INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	
# of Dependents:	Gender:
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address:	
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Current Concerns:

What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change?

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	**Rarely**	**Frequently**	**Very Often**		**Never**	**Rarely**	**Frequently**	**Very Often**
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				

Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				