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Intake Form

Last Name _____ First Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Sex (M/F) _____ Birth Date _____ Referred By _____

May I contact you by email for scheduling purposes? _____ Email Address: _____

Home Phone _____	Can I call you here? _____	Can I leave a message? _____
Cell Phone _____	Can I call you here? _____	Can I leave a message? _____

Briefly tell me about the issues/concerns that have brought you here.

Please check any current or past issues that still affect you.

- | | |
|--|--|
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pregnancy Issues |
| <input type="checkbox"/> Academic/Work Issues | <input type="checkbox"/> Spiritual Concerns |
| <input type="checkbox"/> Childhood Abuse (i.e. physical, sexual, emotional) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Stress/Anxiety | <input type="checkbox"/> Pornography |
| <input type="checkbox"/> Phobias (type: _____) | <input type="checkbox"/> Sexual Identity Issues |
| <input type="checkbox"/> Family Issues (i.e. divorce, alcoholism, domestic violence) | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Alcohol/ Drug Use | <input type="checkbox"/> Relationship Concerns |
| <input type="checkbox"/> Sexual Assault/Rape | <input type="checkbox"/> _____ family |
| <input type="checkbox"/> _____ recently (when: _____) | <input type="checkbox"/> _____ friend |
| <input type="checkbox"/> _____ in the past | <input type="checkbox"/> _____ parent |
| <input type="checkbox"/> Death of Someone Close | <input type="checkbox"/> _____ significant other |
| <input type="checkbox"/> _____ recently (when: _____) | <input type="checkbox"/> _____ roommate |
| <input type="checkbox"/> _____ in the past | <input type="checkbox"/> _____ other: _____ |
| <input type="checkbox"/> Other: _____ | |
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Current medical problems _____

Current medications (*all, including herbal*) _____

Are you currently working with a Personal Physician? _____ Phone Number: _____

Name _____ What for? _____

Have you been on any medications in the past for mental health issues? _____

(Please list) _____

Have you previously seen a therapist? _____ Who/Where? _____

How long ago? _____ For what types of issues? _____

Are you currently seeing a therapist? _____

Have you ever been hospitalized for physical or mental health issues? (*Briefly describe*) _____

Have you had any previous suicide attempts? _____ (*Briefly describe*) _____

If you are currently experiencing any of the following symptoms, please rate them using the number key below.

<i>Never = 0</i>	<i>Seldom = 1</i>	<i>Often = 2</i>	<i>Always = 3</i>
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_____ Difficulty concentrating

_____ Crying

_____ Missing classes/work

_____ Feeling helpless

_____ Feeling uptight

_____ Worrying

_____ Feeling hopeless

_____ Feeling afraid

_____ Lying to others

_____ Feeling out of control

_____ Feelings of self-doubt

_____ Injuring self

_____ Nervous around others

_____ Suicidal thoughts

_____ Memory loss or blackout

_____ Difficulty sleeping

_____ Stealing

_____ Anger

_____ Eating binges

_____ Drinking heavily

_____ Drug use

_____ Feeling guilty

_____ Withdrawing socially

_____ Sexual preoccupation

_____ Physical symptoms (*i.e. headaches, digestive*)

List: _____

Have you seen a health care provider for these? _____

Other: _____

Please use the scale below to answer the following questions.

4=True to a great extent

3=Mostly true

2=Somewhat true

1=Not at all true

My current concerns affect my success in life. _____

My current concerns affect my ability to interact and connect with others. _____

I am optimistic that I will be able to make some positive changes as a result of counseling. _____