Intake Form

Today's Date ____________________

Demographics and Contact

Legal Name _______________________________ Preferred Name ________________

Home Address _______________________________ May I send mail to this address? Yes No

Billing Address _______________________________ May I send mail to this address? Yes No

Home phone: _____________________ May I leave a voicemail? Yes No

Cell phone: _____________________ May I leave a voicemail? Yes No

Which number do you prefer? Home Cell

Email _____________________ May I use email to contact you? Yes No

Emergency Contact _____________________Relationship _____________________

Phone _____________________ May I leave a voicemail? Yes No

Date of Birth _____________________ Age ________ Place of birth _____________________

Legal Sex Female Male Preferred Pronoun _________________

How you identity in terms of gender? ____

How do you identity in terms of sexuality? ____

Relationship Status ________________________ Education (highest level) _____________________

Occupation (former if retired) _____________________ Employment Status__________________

How do you identify in terms of race/ethnicity/culture? ________________________________

How do you identify in terms of spirituality/religion? ________________________________

Chief Concern(s)

What problems or issues are you seeking help for?

____

____

How much distress does the problem cause: Mild Moderate Severe Very severe

What are your goals/intentions for counseling?

____

____

Are you currently or have you ever received mental health or substance use treatment?

____

____

Previously diagnosed mental health conditions

____

____

Have you ever attempted suicide? Yes No If yes, how often and when? ___________________

Drugs and Alcohol

Do you use tobacco? Yes No How much and how often? ______________________

Would you like to quit or cut down? Yes No

Do you drink alcohol? Yes No How much and how often? ______________________

Would you like to quit or cut down? Yes No

Do you use marijuana? Yes No How much and how often? ______________________

Would you like to quit or cut down? Yes No

Do you use substances recreationally? Yes No What? ________________

Would you like to quit or cut down? Yes No

Please check any and all boxes of symptoms/concerns that may apply to you

Depression	Panic/Anxiety attacks	Self harm
Anxiety	Drug and/or alcohol use	Uncontrollable worry
Thoughts of ending your life	Spiritual/religious concerns	Sleep difficulties
Hallucinations/Delusions	Trauma	Family substance abuse
Relationship concerns	Witness/experienced domestic violence	Loss or death of close friend/family
Sleep problems	Sexual abuse/assault	Mood swings
Eating issues	Sexual disfunction	Flashbacks
Self-esteem	Impulsivity	Anger
Body image	Physical violence	Avoidance
Compulsive behavior	Academic/work concerns	Crying spells
Chronic illness	Difficulty concentrating	Racing thoughts
Fatigue	Feeling hopelessness	Guilt
Grief	Identity issues	Insomnia
Irritability	Isolation	Loneliness
Loss of interest	Major life transitions	Mania
Nightmares	Paranoia	Obsessive thoughts
Other:	Other:	Other:

Medical and Physical Health

Primary care doctor/clinic ________________________________ Phone ____________________
Address ________________________________ Date of last physical ______________________
Allergies ______________________ Medical Insurance ______________________

Psychiatrist or Psychiatric Nurse Practitioner (ARNP) ________________________________

Phone ____________________ Address ________________________________

Past and current medical or health concerns (medical problems, surgeries, accidents):

____

____

Do you take any medications, vitamins or supplements? Please provide dosages and for what conditions.

____

____

Family and Lifestyle

Please list members of your family, their ages, and whether they live with you.

____

____

Please list any physical or mental health illness that runs in the family and who has it (cancer, high blood pressure, depression, substance use disorder, etc.).

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How do you spend your free time? Are you happy with your social life?

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Any addition information or concerns you want me to know?

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