COUNSELING INTAKE FORM

PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date:______________________ Birth Date:______________________

Name:____

Address:_______________________________________City/St_______________________ Zip:_____________

Your Phone #'s: (Home)_______________________________, (Work)_______________________________

(Cell):__________________________________ Preferred method of contact:
____

Email Address:____

Your Employment/Job Title/School:____

Person responsible for your bill, if different than above:

____

Referral Source (e.g., how you found out about services)____________________________________

Is it ok to call your home & leave message: Yes_____ No_____; At your work: Yes_____ No_____

Person to contact in case of an emergency (name/phone):___________________________________

In a few words, describe your reason for seeking counseling:_______________________________

____

____

Have you ever had counseling before? ______Yes ______No

If yes, describe and list counselor, estimated number of sessions, any psychiatric hospitalizations:

____

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____

Describe any major changes that have occurred to you or your family in the last few years

(moves, changes in number of family members, marital status, situation or income):

____

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____

Educational history: Last year of school completed: ___________________ (or GED)

College: 1 2 3 4 Degree:________________________________ Other: ___________________________

Single_____ Married______ Separated_____ Divorced____ Remarried_____ Widowed____

Do you have children? ________ Yes ________ No

If yes, list names, ages, and whether they live in your home

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____

____

Has anyone in your family ever had counseling before? If so, for what?______________________

____

Any history of drug/alcohol abuse for self, father, mother, siblings? ____ Yes ____ No

If yes, please describe ____

Do you use alcohol or nonprescription drugs? ____Yes ____No

If yes, describe frequency and type____

List any major health problems for which you have received treatment for in the last 24 months:

____

Primary Care Physician: ____

Phone:_________________________________

Are you taking any prescription drugs at this time? ____Yes ____No

If yes, what type, for what purpose, and who prescribed?

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