Intake History Form

General Information

Name: _____ Today's Date: _____

Name of parent/guardian (if under 18 years): _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Address: _____ (Street and Number)

_____ (City) (State) (Zip)

Home Phone: _____ May we leave a message? Yes _____ No _____

Cell Phone: _____ May we leave a message/text? Yes _____ No _____

Email: _____ *Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Race: _____ Cultural Considerations: _____ Religion: _____

Marital Status: [ ]Single [ ]Married ___/___/_____ [ ]Divorced ___/___/_____ [ ]Separated ___/___/____

On a scale of 1-10 how would you rate your relationship? _____

Present Family

Name and date of birth of spouse (if applicable) _____

Name(s) and date(s) of birth of any children (if applicable) _____
_____

_____

How would you describe your present home life? ____ excellent ____ good ____ fair ____ poor ____ very poor

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Medical History

Primary Physician: _____ Phone Number: _____

When was your last physical exam? ____/____/_____ Anything noteworthy? _____

_____

Are you presently taking any medications? Yes _____ No _____ If yes, what and why?

_____

How would you rate your physical health? _____ excellent _____ good _____ fair _____ poor _____ very poor

Are you currently experiencing any physical problems? Yes _____ No _____ If yes, describe:

_____

Have you ever been hospitalized for an emotional or mental illness? Yes _____ No _____ If yes, describe:

_____

Do you drink alcohol more than once a week? Yes _____ No _____ If yes, how often? _____

Is alcohol an area of concern for you? Yes _____ No _____

Do you engage in recreational drug use? Yes _____ No _____ If yes, how often? _____

Emotional History

Have you ever sought professional counseling before? Yes _____ No _____ If yes, describe:

_____

Are you seeing another counselor now? Yes _____ No _____ If yes, name and phone number:

_____

Why are you seeking counseling now? _____

_____

How long have you been experiencing this difficulty? _____

How severe do you believe this problem is? _____ Just an irritant _____ Mildly upsetting _____ Severe

_____ Extremely severe _____ Totally incapacitating

Do you feel like committing suicide? If yes, please explain: _____

_____

What kinds of things have you done in the past to deal with problems? _____

_____

Prior to the problem you are now working on, how would you describe your emotional make-up?

_____ Extremely stable _____ Struggled more than others _____ About average _____ Always struggling

Whose idea was it that you come in for counseling? _____

Employment

Are you currently employed? Yes _____ No _____ If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

Are you satisfied with your current income level? Yes _____ No _____

Family of Origin

Briefly describe the way it felt growing up in your childhood home. _____

_____

Briefly describe your father's personality and the way he treated you and other members of the family.

_____

_____

Briefly describe your mother's personality and the way she treated you and other members of the family.

_____

_____

What patterns or behaviors of your parents do you want to see in yourself in your own family?

_____

_____

What patterns or behaviors of your parents do you want to unlearn?

_____

_____

Describe your brothers and sisters and how you related to them during childhood.

_____

_____

Describe any turning points or significant events during your childhood that impacted you (divorce, marriage, death, move, etc.)

_____

_____

About You

What do you consider to be some areas you wish to work on? _____

_____

_____

What do you consider to be some of your strengths? _____

_____

_____

Is there anything else you feel we should know, or that you are concerned about? _____

_____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

_____