Date_____

Intake Information

Name:_____ DOB: _____ Age: _____

Address: _____Social Security No. _____

City:_____ State: _____ Zip: _____

Insurance Provider: _____Group No._____

Home Phone: (____) _____ Cell Phone: (_____)_____

Work Phone: (_____) _____ OK to leave a message? _____Yes _____No

Race: _____ Sex: Male Female Marital Status: S M W D Sep

Emergency Contact: _____ Phone: (____) _____

Next of Kin: _____ Phone: (____) _____

Referral Source: _____ Phone: (____) _____

Employer & Job Duty_____

_____ Phone: (____) _____

Spouse: _____ Phone: (____) _____

Others in household:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Have you had previous counseling? ____Yes ____No If yes, how long ago?:_____

_____

What are your chief concerns today? _____

_____

_____

_____

Please explain any life changes or stressors you have experienced in the past year? _____

_____

_____

_____

Health and Social Information

1. How would you rate your current physical health (please circle):

Poor Unsatisfactory Satisfactory Good Excellent

2. Do you have any of the following medical conditions?

___ Incontinence
___ Gastrointestinal (Diarrhea, Constipation)
___ Sleep Apnea
___ Neurological (Seizures, Head Injury, Stroke)
___ Hypertension
___ Diabetes
___ Thyroid Problems
___ Respiratory
___ Pain (if checked, needs further assessment)
___ Headaches
___ Shortness of breath
___ Dizziness/Fainting
___ Allergies/Hay Fever
___ Cardiovascular
___ Sexually Transmitted Disease
___ Eating Disorder
___ Hepatitis/Liver Dysfunction
___ Anemia
___ Arthritis
___ Allergies (food and/or medication)
___ Menstrual Irregularity
___ Pregnant (if so, high risk?)
___ Lactating
___ Planning pregnancy
___ Hx stillbirths, miscarriages
___ Hx abortions

3. Are you currently experiencing pain? ____ Yes ____ No If Yes, where?_____

4. Rate the pain using the 1-10 Numeric Pain Intensity Pain Scale:

1 2 3 4 5 6 7 8 9 10
(No Pain) (Moderate Pain) (Worst Possible Pain)

5. Are you presently being treated for pain? ____Yes ____No If yes, please list pain medication:
_____

6. Primary Care Physician:

Name: _____ Phone: _____

Address: _____

7. Please list any medications you are currently taking, including over the counter:_____

_____

_____

_____

8. Do you regularly consume Alcohol? ____Yes ____No If yes, how often?
_____

9. Do you engage in recreational drug use? ____Yes ____No If yes, how often?
_____

10. Have you ever had Suicidal Ideation or Suicide Attempt? ____ Yes ____ No
Comments:_____
_____

11. Have you ever had Homicidal Ideation or Homicidal Attempt? ____Yes ____ No

Comments:_____

_____

12. Have you experienced any of the following within the last 3 months:

___Extreme depressed mood ___Extreme mood swings

___Rapid Speech ___Extreme Anxiety

___Panic Attacks ___Phobias

___Sleep Disturbances ___Hallucinations (visual and/or auditory)

___Delusions ___Unexplained loss of time

___Unexplained memory lapses ___Alcohol/Substance Abuse

___Frequent body complaints ___Body Image problems

___Repetitive thoughts (obsessive) ___Repetitive Behaviors (obsessive)

13. Are you currently experiencing any factors that may endanger your safety or the safety of your family? (e.g., physical abuse, sexual abuse, domestic violence, elder or child abuse) ____

_____

_____

_____

Other Comments:

_____

_____

_____

Client Signature:_____Date:_____

Therapist Signature:_____Date:_____