INTAKE FORM

Date_____/_____/__________

Name:____

Address:____

Home Phone:____________________________Cell:__________________________________

Okay to leave voicemail? ______Yes ______No Email:_________________________________

Date of Birth:____________________________Age:______________Gender:______________

Emergency Contact:_________________________________Phone:______________________

Relationship to Client:____

Occupation:____________________________Current Employer:________________________

Insurance Carrier:____

Referral Source (i.e. Psychology Today, Primary Care Provider, Psychiatrist, friend):

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Briefly Describe your reasons for seeking counseling:___________________________________

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Please check all concerns that are troubling you:

___Depression	___Loneliness/shyness	___Identity concerns
___Anxiety	___Romantic/Marital problems	___Cultural Issues
___Stress	___Coping with break-up	___Discrimination
___Anger/Hostility	___Expressing feelings	___Friendship problems
___Self-cutting/self-harm	___Self-esteem	___Insomnia
___Suicide concerns	___Assertiveness problems	___Health concerns
___Substance abuse	___Family issues	___Sexual concerns
___Sexual abuse	___Interpersonal Violence	___Sexual Orientation
___Sexual Assault	___Harassment/Stalking	___Career concerns
___Trauma	___Grief	___Pregnancy
___Fertility/Miscarriage	___Body Image	___Procrastination
___Legal Issues	___Financial Concerns	___Leaning Disability
___ADHD	___Memory Issues	___Caregiver concerns

Have you had prior counseling or psychotherapy? _____Yes _____No

If yes, please specify dates, duration and issues addressed:

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Medications (including herbal supplements):

Current: ____

Past:____

Prior hospitalization: _____Yes _____No If yes, please provide dates and reason for hospitalization: ____

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Relationship Status: ____Single ____Married ____Partnered ____Separated ____Divorced

____Widowed

Partner's Name___________________________Age:_______Occupation:____________________

Signature:____Date:_____________