Counseling Intake Form

Date: _____

Personal Information:

Name: _____ DOB: _____ Sex: ___

Address: _____

_____

Email Address: _____

Phone Number: _____
Is it ok to leave voicemails: __ Yes __ No Is it ok to send a text message: __ Yes __ No

Occupation: _____ Employer: _____

Religious background: _____ Participation: _____

Marital Status: _____

Presenting Issue:

What issue do you want to address in therapy?

_____

_____

_____

_____

Have you previously suffered with this issue? If so, when and for how long?

_____

_____

Have you sought treatment for this issue in the past? If so, please discuss the treatment you received (for example, therapy, medication, etc.) and if it was helpful.

_____

_____

Previous Counseling: _____ Dates:_____

Psychiatric Hospitalizations:_____Dates: _____

Detox/Rehab: _____Dates: _____

Current Symptoms (Check All That Apply):

☐ Anxiety	☐ Appetite Changes*	☐ Avoidance	☐ Other:
☐ Depression	☐ Energy Changes*	☐ Fatigue	_____
☐ Hallucinations	☐ Impulsivity	☐ Irritability	_____
☐ Substance use	☐ Panic Attacks	☐ Racing Thoughts	
☐ Sleep Changes*	☐ Suspiciousness	☐ Crying Spells	
☐ Anger	☐ Hopelessness	☐ Suicidal Thoughts	
☐ Mood Swings	☐ Difficulty concentrating	☐ Easily frustrated	

* Please discuss whether there has been an increase or decrease or more variation than usual:

_____

_____

Medical History:

Do you have any current medical conditions? _____

_____

_____

What medications are you currently taking? _____

_____

_____

Any allergies? _____

Primary Care Physician: _____

How would you describe your current physical condition? _____

_____

Emergency Contact Information:

Name: _____ Relationship to client: _____

Address: _____

_____

Phone: _____

If you are the parent or legal guardian of a client, please complete the following with your information (if different from the client):

Name of parent/legal guardian: _____ Date of Birth: _____

Address: _____

_____

Phone Number: _____

Referral Information:

Referred by or found services through: _____

Form of Payment:

The following forms of payment are accepted: cash or check only. Payment is due at the time services are rendered.

I certify the information provided above is accurate to the best of my knowledge. I agree to update any changes in information as soon as possible.

_____ _____

Client Printed Name Date

_____

Client Signature