Confidential Counseling Intake Form

Name: _____ ***Date:*** _____

Date of Birth: _____ ***Age:*** _____ ***Gender:*** _____

Home/Cell phone: _____ ***OK to leave a message?*** _____

Work phone: _____ ***OK to leave a message:*** _____

Email: _____ ***OK to email you?*** _____

Home Address: _____

Current or Former Occupation: _____

Educational Background: _____

Emergency Contact Name: _____

Emergency Relationship: _____ ***Emergency Phone:*** _____

Permission to contact in an emergency? _____

Please give a brief description of your present concerns:

Describe how you're feeling generally:

What would you like to change?

If there are stresses in your family life or work, please describe:

What are your hesitations, if any, about seeking counseling?

Have you been in therapy before? If so, please give dates, type of treatment, and results:

Have you had any thoughts of suicide? ***If so, when?***

Do you have any thoughts of suicide now?

Have you ever harmed yourself or others?

Is there anything else you think it would be helpful for me to know?

<u>Family Information:</u>

Where did you grow up?

What is your cultural/ethnic background?

What was your religious upbringing, if any? ***Current affiliation?***

Tell me about your childhood and family of origin:

Siblings: How many? Where are you in the birth order? Have any died?

Are your parents alive? If deceased, how old were you?

Family Alcoholism, Domestic Violence, or Abuse? Please specify:

Did you experience what you consider to be childhood or other traumas? If yes, please indicate what they were:

Marital status – name of spouse, # of marriages:

Children – ages and genders:

Are you currently under a doctor's care?

Please specify any concerns about your physical health:

List all medications you take and the purpose of each:

Please circle any of the following you have experienced in the last month:

Headaches	***Stomach trouble***	***Skin problems***	***Dizziness***
Heart palpitations	***Unusual fatigue***	***Restlessness***	***Chest pains***
Aversion to touch	***Tension***	***Panic***	***Tremors***
Rapid heartbeat	***Loss of motivation***	***Fainting***	***Poor appetite***
Sleep disturbance	***Can't relax***	***Agitation***	***Blackouts***
Hearing things	***Excessive sweating***	***Tingling***	***Irritability***
Persistent anger	***Crying spells***	***Emotional Numbing***	***Tics***
Memory problems	***Muscle spasms***	***Self blame***	