INTAKE FORM

Today's Date: _____

Please take the time to fill out this form thoughtfully. The information you provide on this form will remain confidential between you and your therapist. If there are any questions you are not comfortable answering, please feel free to skip them. Your thorough completion of the questionnaire is strongly encouraged, as your responses enable me to make a focused assessment and support efficient treatment planning. Thank you.

GENERAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Address: _____

_____

Home Phone: (_____)_____
May we leave a message for you here? ☐Yes ☐No

Cell Phone: (_____)_____
May we leave a message for you here? ☐Yes ☐No

If contact is necessary (for appointments, etc.) which number do you prefer? ☐Home ☐Cell

Employer: _____ Occupation: _____

Are you content in/with your current employment? ☐Very ☐Moderately ☐Very little ☐Not at all ☐Unsure

Last year of school completed: 9 10 11 12 GED College/University: 1 2 3 4 Graduate: 1 2 3 4 5 6

Certificate/Diploma/ Degree pursued/accomplished _____

RELATIONAL INFORMATION

Current Relationship Status: (check all that apply)
☐Single ☐Exclusively dating ☐Engaged ☐Married ☐Living together
☐Common-law ☐Separated ☐Divorced ☐Widowed

If in committed relationship, for how long? _____

How long have you known your partner? _____

Partner's Name: _____ Partner's Age: _____

Number of previous marriages for you? _____ For your partner? _____

If widowed, separated, or divorced, for how long? _____

With whom do you currently live? *(check all that apply)*
☐Alone ☐Spouse ☐Children ☐Parent(s) ☐Sibling(s) ☐Boyfriend ☐Girlfriend ☐Other _____

PHYSICAL HISTORY

How would you rate your overall health? *(nutrition, exercise, sleep)*
☐Poor ☐Below average ☐Average ☐Above average ☐Excellent

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling: *(including pregnancies, or related treatments)*

_____

_____

_____

_____

Please list all current medications you are taking, and the reasons.
(List even if you seldom use, or take only as needed.)

Medication	Reasons
Medication	Reasons
Medication	Reasons
Medication	Reasons
Medication	Reasons
Medication	Reasons
Medication	Reasons

PRESENTING ISSUES AND GOALS

Please describe briefly why you are coming to counseling? What are your issues, concerns?

_____

_____

_____

_____

What do you consider to be some of your strengths and weaknesses?

Strength	Weakness
Strength	Weakness
Strength	Weakness

What do you hope to gain or change by coming for counseling?

_____

Do you consider yourself to be spiritual or religious?
☐Yes ☐No
If yes, describe your faith or belief.

_____

_____

_____

Have you had any previous counseling, psychiatric treatment, or residential/in-patient care?
☐Yes ☐No

Are you currently experiencing any suicidal thoughts?
☐Yes ☐No

Have you attempted suicide in the past?
☐Yes ☐No
If yes, when?_____

Have any of your friends or family ever committed or attempted suicide?
☐Yes ☐No