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Intake Information

Date: _____

NAME: _____

ADDRESS: _____Apt:_____

CITY: _____Zip:_____

BIRTHDATE: _____ AGE: _____

PLEASE INDICATE HOW I CAN CONTACT YOU. YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS. IF YOU DO NOT WANT YOUR BILLS OR CONFIDENTIAL INFORMATION SENT TO YOUR HOME ADDRESS, I WILL SEND THEM TO A DIFFERENT LOCATION IF YOU WISH.
ALTERNATIVE ADDRESS FOR CONFIDENTIAL COMMUNICATIONS TO BE SENT_____

PLEASE INDICATE WHICH PHONE IT IS OKAY TO LEAVE A MESSAGE ON

Phone: **Home**_____msg?_____ **Email: _____**
Cell_____msg?_____ **Text message OK?: (circle one)** YES NO

Who do we contact in case of an emergency?
Name/Phone: _____

Who Referred you?_____
Do I have your permission to contact the listed referring person to thank them?: _____YES _____NO

Family Members and Others Now in Household

Name	Relationship	Age	Marital Status

Religion:_____Education:_____

Employer:_____Occupation:_____
How many hours/week are you employed?____
How long have you worked at your current job?_____
Have you ever been fired or let go from a job?_____
If so, please explain circumstances_____
_____
Has there been a major change in your income recently or has income stopped? ___yes ___no

Legal history:

Have you ever been arrested? Yes No

Have you ever been convicted of a crime? Yes No

Are you presently on parole or probation? Yes No

If yes, please explain_____

Are you currently, or have been involved in a lawsuit? ____Yes _____No
If yes, please explain:_____

Marital/Partner History--Please give year of marriage

From _____To_____

From _____To_____

How many children do you have?_____

Do they live with you? Yes No

Are you currently in litigation over custody or divorce? _____yes ____no If yes, please explain_____
_____
_____

Counseling History

Have you been in counseling in the past? ____yes ____no Reason for counseling_____
Have those issues been resolved? ____yes ____no Would you like to continue working on them? ____yes ____no

Therapist name _____dates of counseling_____
Therapist name _____dates of counseling_____
Therapist name _____dates of counseling_____

Have you ever considered suicide? If so please explain_____
_____
Are you currently having suicidal thoughts?_____
Have you ever experienced physical, sexual or emotional abuse? No Yes
If so please explain:_____
_____
_____
Have you ever been hospitalized for Psychiatric Reasons? ___yes ____no
When and Where_____

Do you have a psychiatrist that you are currently seeing? ___yes ___no If so, please indicate name and address of psychiatrist_____
_____

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you. Please use the following scale:

Not at all 1 A little bit 2 Quite a bit 3 Extremely 4

1. Dealing with stress or pressure	1	2	3	4
2. Feeling sad, depressed or down	1	2	3	4
4. Difficulties related to sexual orientation/identity	1	2	3	4
5. Family relationships	1	2	3	4
6. Abuse in relationship with romantic partner/spouse	1	2	3	4
7. Feeling anxious, worried, or panicky	1	2	3	4
8. Feeling unmotivated, difficulty concentrating	1	2	3	4
9. Feeling irritable, tense, angry, or hostile	1	2	3	4

10. Money or finances	1 2 3 4
11. Feeling isolated and uncomfortable with others	1 2 3 4
12. Values, beliefs, or spirituality concerns	1 2 3 4
13. Sexual abuse in childhood	1 2 3 4
14. Physical or verbal abuse in childhood	1 2 3 4
15. Someone else's habits or behaviors	1 2 3 4
16. My own unwanted habits or behaviors	1 2 3 4
17. Rape, sexual assault, or sexual harassment	1 2 3 4
18. Eating concerns (i.e., bingeing, restricting, vomiting, laxative use)	1 2 3 4
19. Weight or body image concerns	1 2 3 4
20. Problems with romantic partner/spouse	1 2 3 4
21. Sexual concerns (i.e., pregnancy, sexual functioning, STD's)	1 2 3 4
22. Physical health problems	1 2 3 4
23. Urge to harm others	1 2 3 4
24. Concerns about my own drug or alcohol use	1 2 3 4
25. Thoughts of harming myself	1 2 3 4
26. Other (please explain below):	1 2 3 4

_____
_____

Substance Abuse/Compulsive Behavior History

Have you ever been hospitalized for Substance abuse problems, or any type of compulsive behavior/addiction? ___yes ____no When/Where, Please explain_____

Please show your history of substance abuse/compulsive behavior, using the following scale
1-Never use 2-Monthly 3-Weekly 4-Daily

History: Current Past
Alcohol_____
Tobacco_____
Caffeine_____
Cocaine_____
Marijuana_____
Stimulants_____
Diet Pills_____
Narcotics/Pain Killers_____
Sleeping Pills_____
Gambling_____
Shopping_____
Pornography_____

Are you, or have you ever been, concerned that you might have an addiction?_____ Please explain_____

Have you ever lost time from work due to substance use or addictive behaviors?_____

Have you ever been arrested for DUI or other alcohol/drug-related offenses?
____Yes ___No, if so how many times?_____

Have you ever been arrested for shoplifting?_____

Have you ever chosen to quit/cut down?_____Yes_____No

Have you ever experienced withdrawal symptoms_____Yes_____No

Have other (family, friend, spouse, MD, employee) expressed concern or anger about your alcohol/drug use?
_____Yes _____No

Has anyone in your family had a history of heavy alcohol/drug use? No Yes
If yes who_____

Medical History/Medication

Current Medication	Dose Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician:_____
Address:_____
City:_____Zip_____
Office Phone number:_____
Do we have your permission to send information regarding your care to your Primary MD?
Yes_____No_____Initial_____

Family History **Relationship:**

Emotional Problems	Yes	No
Substance Abuse	Yes	No

Personal History

Emotional Problems	Yes	No	Substance Abuse	Yes	No
Cardiovascular Disease	Yes	No	Hypertension	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Abnormalities	Yes	No	TuberculosisYes	No	
Head Injuries	Yes	No	Cancer	Yes	No
Respiratory Disease	Yes	No	Other_____		
Neurological Disorders	Yes	No			

Do you smoke?_____How much per day_____For how many years_____
Caffeine?_____How much per day_____For how many years_____

Please provide a summary of your counseling needs and goals. What brought you here, and what problems would you like to address in counseling: _____

_____
_____
_____
_____
_____

Signature of Patient or Guardian_____ **Date**_____