Confidential Intake Information

Please fill this out to help me know more about you. It will save time during our sessions so we can focus on what's most important to you.

Name ______________________________ Date ____________
Address ____

____

Phones: Home ______________ Work ______________ Cell ______________
OK to mail to this address? Yes No. OK to leave messages at these phone numbers? Yes No
Email address ____

May we send you the free, quarterly e-newsletter? Yes No

Current Employment ______________________________ Highest grade of education ____________

Do you enjoy your work? Yes No Are finances a major stressor for you? Yes No

Marital status: Single Married (yrs _______) Partnered Widowed Divorced
Previous marriages, significant relationships: ______________________________

____

Who is living at home? Please list all adults and children

Name (List yourself first)	Occupation	Age/Date of Birth	Relationship to you

How were you referred here? ______________________________
Have you experienced counseling before? Yes No • Was it helpful? Yes No Somewhat
With Whom? ____
Reasons for prior therapy ______________________________

____

Have you ever been diagnosed with a mental disorder? No Yes ____________________

Have you or any of your family had problems with depression, anxiety, suicide attempts, mental illness?
No Yes If "Yes," please explain.

____

____

Medical History: Have you ever had any major surgery, illness, accidents or hospitalizations?

____

____

Are you currently taking any medications? (Please list the medication and purpose.)

____

____

Do you or any of your family members use coffee, caffeine drinks, or smoke cigarettes?

____

____

Have you or your family been affected by alcohol or recreational drug use? No Yes, in what way?

____

____

Please continue with the questions on the back of this paper

Are you generally healthy? ____

Do you sleep well? ____

Do you eat balanced meals regularly? ____

Do you exercise regularly? Please specify ____

Among your friends and family who do you count on for support?

____

____

Please describe yourself spiritually ____

____

____

Please describe what you want to work on in therapy. (What do you want to be different.)

____

____

____

How long has this been troubling you?

____

How would you estimate the severity of the problem? Mild Moderate Serious Severe

____

What else is related to this problem?

__ Abuse: Physical, Sexual, Emotional, Spiritual
__ Adjustment Difficulties
__ Alcohol, Drug Use
__ Anger, Hostility, Arguing, Irritability
__ Anxiety, Worry
__ Appetite, Weight Control, Diet Issues
__ Childhood Issues (Your Childhood)
__ Children, Childcare, Parenting
__ Communication Concerns
__ Concentration, Motivation
__ Conflicts: Relational, Personality
__ Decisions Making Difficulties
__ Depressed Mood, Sadness, Crying
__ Divorce, Separation
__ Emotions, Mood Swings
__ Family Difficulties
__ Fatigue, Tiredness, No Energy
__ Fears Or Panic
__ Feeling Unworthy
__ Financial, Money, Spending Concerns
__ Forgiveness Issues
__ Grief, Loss, Mourning
__ Guilt, Shame
__ Hopelessness
__ Isolation, Loneliness, Shyness
__ Marriage: Conflict, Coldness, Infidelity
__ Nervousness, Tension
__ Obsessions, Compulsions
__ Personal Growth
__ Physical Health, Pain
__ Pregnancy, Abortion, Miscarriage
__ Recurring Thoughts
__ Self-Esteem
__ Sexual Concerns
__ Sleep Problems
__ Spiritual/Faith Concerns
__ Suicidal Thoughts, Feelings
__ Unable To Have Fun
__ Work, Career Concerns, Goals, Choices.
__ Other ______________________________
__ ______________________________
__ ______________________________
__ ______________________________

• As specifically as possible, what are your expectations of counseling?

____

____

____

• Do you have any concerns about the counseling process?

____

Thank you for taking the time to fill this out.