Confidential Counseling Intake Form

Please complete this form, thus reducing the amount of session time your counselor spends obtaining your basic information. Thank you for your cooperation. PLEASE NOTE: This information is for counseling use only. It is considered confidential: we will not release information to anyone (Accept as required by law – See informed consent and privacy notices), nor will we contact those listed below without your permission.

TODAYS DATE:

GENERAL INFORMATION

Full Name ______________________________ Preferred Name/Nickname _______________

Address ____

Home Phone ____________________________________ (Ok to leave a message? Yes / No)

Cell Phone _____________________________________ (OK to leave a message Yes / No)

Email Address __________________________________ (OK to send a message Yes / No)

Date of Birth ________________________ Age _____________ Sex (M/F) _______________

How did you hear about The Heights Counseling and Wellness? ____________________________

In case of emergency, who is a relative or friend that I can call?

Name ________________________ Relationship ______________ Phone ______________

MARITAL STATUS

______ Single

______ Married for ________ (years) I have been married _______ times.

______ Divorced for ________ (years) after a marriage of _______ (years).

______ Separated for ________ (years) after a marriage of _______ (years).

Is your marriage an area of concern that you would like to address in counseling? _______________

____

Spouses name and occupation: ____

Names and ages of children, if any ____

Where were you raised? ____

EDUCATION AND OCCUPATION

Current Student? Yes __________ No __________ School ___________________________

Highest degree obtained, and major ____

Current Occupation? ___________________________Are you happy with your work?___________

COUNSELING HISTORY

Have you ever consulted a therapist before? _______When? ___________ How Long?___________

Major themes discussed? ____

____

What are some things gained/learned from that counseling experience? _______________________

____

MEDICAL HISTORY

Any medical problems we should be aware of? ____

Do you think that now or in the past you have struggled with some kind of addiction? _____________

If so,what? ____

Have you ever seriously considered or attempted suicide? _______When? ____________________

Have you been or are you taking any medications? ____________ If yes, what medications and for what problems? (List dosage if you know it) ____

Current Physician ________________________ Specialty _____________________________

Date of last physician contact ________________ Date of last full physical ____________________

Other Physician__________________________ Specialty_______________________________

Date of last physician contact ____

	Yes	No	Past/Present	Amount/Frequency
Alcohol Use	____	____	______________	____________________
Street Drugs	____	____	______________	____________________
Tobacco Use	____	____	______________	____________________
Caffeine Use	____	____	______________	____________________
Exercise	____	____	______________	____________________
Balanced Diet	____	____		____________________

CURRENT COUNSELING DESIRES

What do you see as the chief problem you would like to address with your counselor?

____

____

What have you tried that has or has not helped? _____________________________________

____

Who are your primary supports? ____

____

Family History:	Age or Date of Death	Health
Natural Mother	____	____
Natural Father	____	____
Step-Mother	____	____
Step-Father	____	____
Siblings (sisters, brothers)		
__________	____	____
__________	____	____
__________	____	____
__________	____	____
Children:		
__________	_____	_________
__________	_____	_________
__________	_____	_________
__________	_____	_________

Has **anyone** in your family experienced any of the following:
(Check any which are appropriate)

___schizophrenia
___depression
___mood swings
___anxiety/panic attacks
___suicide or attempts
___sexual abuse
___physical abuse
___alcohol abuse
___drug abuse
___imprisonment
___learning disability
___attention deficit
___mental retardation
___dementia/brain damage

Please respond to each item
(Y or N)

___No energy
___Cannot enjoy life
___Memory problems
___Anxiety
___Fatigue
___Anger outbursts
___Shortness of breath
___Sweating
___Hot flashes
___Relives past event
___No love feelings
___Fears
___Chest pains
___Decisions difficult
___Racing thoughts
___Foolish business investments
___Hard to make friends
___Work problems
___Out of control behavior
____Take pain killers often
____Mood swings
____Unusual experiences
____Physical numbness
____Panic attacks
____Vomiting
____Miscarriage
____Impaired vision
____Back pain
____Drug use

____Insomnia
____Low self-esteem
____Poor appetite
____Headaches
____Nightmares
____Heart palpitations
____Clammy hands
____Startles easily
____Flashbacks
____Hopeless feelings
____Sexual difficulties
____Suicidal thoughts
____Overly confident
____Distractibility
____Sexual indiscretions
____Socially withdrawn
____Eating disorder
____Drinking alcohol
____Seeing things
____Excess energy
____Unsure of reality
____Wish to die
____Confusion
____Weight change
____Abortion
____Impaired hearing
____Muscle spasms
____Tremors
____Depressed

____Guilt feelings
____Overeating
____Dizziness
____Unwanted thoughts
____Racing heart
____Stomach problems
____Sleeps too much
____Always on guard
____Apathetic
____Numbing out
____Distrustful
____Pressured speech
____Buying sprees
____High risk activities
____Family arguments
____Often physically sick
____Hearing voices
____Loosing track of time
____Slowed thinking
____Physical violence
____Unsure of identity
____Seizures
____Pregnancy
____Sporadic dieting
____Blackouts/fainting
____Hypertension
____Hallucination