Counseling Intake Form

Please complete the following information. You may wish to ask a family member for assistance.

Name _____ Date _____

Age and Date of Birth _____

Name and Contact Information of Primary Care Physician: _____

_____

Are you or have you been under the care of a Psychiatrist: Yes No

If yes, please provide the name and contact information of your Psychiatrist:

_____

_____

Do you give permission to provide regular updates to your Psychiatrist or primary care physician?

Yes No

What are the problem(s) to which you are seeking help? _____

_____

What are your goal(s) while participating in counseling? _____

_____

Current Symptoms Checklist: (check once for any symptom you may be experiencing, circle for major symptoms):

( ) Depressed Mood	**( ) Racing Thoughts**	**( ) Excessive Worry**
( ) Unable to Enjoy Activities	**( ) Impulsivity**	**( ) Anxiety Attacks**
( ) Sleep Pattern Disturbance	**( ) Increase Risky Behavior**	**( ) Avoidance**
( ) Loss of Interest	**( ) Increased Libido**	**( ) Decreased Libido**
( ) Concentration/Forgetfulness	**( ) Hallucinations**	**( ) Decreased Need for Sleep**
( ) Change in Appetite	**( ) Suspiciousness**	**( ) Excessive Energy**
( ) Excessive Guilt	**( ) Increased Irritability**	**( ) Crying Spells**

How long have you experienced any of the above symptoms? _____
Have you ever had feelings or thought that you didn't want to live ( ) yes ( ) no

<u>If YES, please answer the following questions. If NO, please skip to Past Medical History.</u>

Do you *currently* feel that you don't want to live ( ) yes ( ) no

Have often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (10 being the strongest), how strong is your desire to kill yourself currently?

_____

__

_____

Would anything make it better? _____

Have you ever thought about how you would kill yourself?_____

Is the method you would use readily available?_____

Is there anyone or anything that would prevent you from acting on these thoughts?_____

_____

Have you ever tried to kill or harm yourself before?_____

_____

Do you have a list of people you can call when you are feeling this way?_____

_____

Do you have access to guns? If yes, please explain. _____

_____

PAST MEDICAL HISTORY

ALLERGIES _____

Past Hospitalizations, reason and date:

_____

_____

List ALL current prescription medication and how often you take them.

Medication Name **Daily Dosage** **Estimated Start Date**

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current Medical Problems: _____

Past Medical Problems:_____

Do you have any concerns about your physical health that you would like to discuss? yes no

Past Psychiatric History:

Outpatient Treatment: ( ) Yes ( ) No If yes, please describe when, by whom and nature of treatment.

Reason Dates Treated By Whom

_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use? ( ) yes ( ) no

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink alcohol? _____

What is the most number of drinks you will drink in a day? _____

Have you ever felt that you should cut down on your drinking or drug use? _____

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) yes ( ) no

Do you think you may have a problem with alcohol or drug use? ( ) yes ( ) no

Have you abused prescription medication? ( ) yes ( ) no

If yes, which ones and for how long? _____

_____

_____

Do you smoke? ( ) yes ( ) no

cigarettes cigars pipe chewing tobacco vape

How many packs per day? _____ For how many years? _____

Have you ever tried to quit? ( ) yes ( ) no

If yes, what methods have you tried? _____.

How long were you successful? _____.

Legal History:

Have you have been convicted of a crime? _____.

Do you have any pending legal problems? _____.

Spiritual Life:

Do you belong to a particular religion or spiritual group? _____.

If yes, what is the level of your involvement?

Do you find it helpful?

Vocational History:

Are you working?_____.

What is the last job you held?_____.

Highest Grade completed?_____.

Is there anything else that you would like us to know?

_____

_____

_____

Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Emergency Contact _____ Telephone: _____