Counseling Intake Form

Please provide the following information below needed for our records. All information will be held confidential in your client file. If there are questions that you do not wish to answer at this time, feel free to leave them blank. Please bring the completed form with you to your first session or email a copy prior to your appointment.

Name of individual inquiring about counseling (if other than client):

_____
(Last) (First) (Middle initial)

Name of client: _____
(Last) (First) (Middle initial)

Age: ___ Birthdate: _____ Gender Identity: _____ Pronouns: _____

Home Address: _____
(Street Number)
_____
(City) (State) (Zip Code)

Phone: _____ ____ yes ____ no (okay to leave a message)
Parent's Phone (if applicable): _____ ____ yes ____ no (okay to leave a message)
Email: _____ ____ yes ____ no *please note that email is not always considered confidential* (okay to email a message)

How did you find out about Resilience 1220? _____

Emergency Contact Information:
_____
(Name) (Relation) (Phone #)

What days and times are you available to come in for therapy?

Mon ___ Tue ___ Wed ___ Thurs ___ Fri ___ Sat ___

_____ _____ _____ _____ _____ _____
(Time)

Do you have any preferences in a counselor? (ex. Male or female, specialty)_____
_____

Have you previously received any type of mental health services, such as counseling or psychiatric services ? ___ yes ___ no

If yes:

_____

(Name)

Do you currently have health insurance? ___yes ___no

If yes, what kind? _____

Health and Medical

Have you previously been diagnosed with a mental health condition? ___ yes ___ no

If yes, what was your diagnosis(s)? _____

Have you ever been hospitalized for a mental health need? ___yes ___no

Please list current and past prescription psychiatric medication that you are taking or have taken, including dose and frequency:

_____

_____

_____

How would you describe your current physical health? (please circle one): Poor

Unsatisfactory Satisfactory Good Excellent

Please list any current medical conditions:

_____

_____

Are you having any trouble with your sleeping or eating patterns ?(if so, please describe):

_____

_____

_____

Please check from the following list any items that you have experienced recently:

___ Loss of interest in previously enjoyed activities
___ Overwhelming sadness
___ Crying often
___ Feeling hopeless
___ Overwhelming anxiety, panic, or worry
____Frequent physical complaints (headaches, etc)
___ Significant change in weight
___ Trouble falling asleep or staying asleep at night
___ Racing or disorganized thought patterns
___ Thoughts of suicide
___ Irritability or anger
___ Mood shifts
___ Self Mutilation
___ Use of alcohol or recreational drugs

Family Information

Do you have any siblings? If so, please list with ages:
_____

Who lives in your home?
_____

Who do you turn to for support in your family?
_____

Are there any conflicts at home that are hard to handle? If so, please describe:
_____

Please list any mental health conditions that exist within your family, as well as the family member with the condition:
_____
_____

Is there a history of drug/alcohol abuse and addiction in your family? If so, please describe:
_____
_____

Is there any history of suicide in your family? If so, please list:_____

School and Social Life

Do you currently attend school? __ yes __ no If yes: _____
(name of school)

Do you enjoy school? ____ yes ____ no

If no, what would you change? _____

Are you being bullied or picked on?_____

Are you happy with your social life ? __ _____

What kind of activities or coping strategies do you use when you are stressed or overwhelmed?
_____
_____

What do you view to be your strengths as a person?
_____
_____

Briefly describe what has brought you to therapy at this time and what goals you would like to accomplish during therapy.
_____
_____
_____
_____

Are you interested in learning about our groups and other programming? ___ yes ___ no

-STOP-

Internal Use Only

Date of first contact: _____
Date intake was completed: _____
Completed by phone: ___ yes ___ no
Completed with parent: ___yes ___no
Assessed for suicide? (if they checked “thoughts of suicide”) ___yes ___n/a
Does client meet criteria for services? ___ yes ___ no
If no, referral provided: _____

Therapist assigned: _____
Location of service: _____
Date of first appointment: _____
Client # _____

Other Notes:
_____
_____
_____

Discharge Date: _____
Number of Sessions Attended:_____
Discharge Notes:
_____
_____
_____