Intake Information

Date of Initial Appointment: _____

Patient Name:_____ Date of Birth _____

Primary Reason for seeking counseling at this time

_____

_____

_____

Check any of the following that you are experiencing:

Aggression	Fatigue	Panic Attacks
Alcohol Use	Flashbacks	Phobias/Fears
Anger	Grief	Poor Judgment
Anxiety	Hallucinations	Self-Esteem Problems
Chronic Pain	Heart Palpitations	Sexual Difficulties
Compulsive Behavior	High Blood Pressure	Sleep Problems
Concentration Problems	Hopelessness	Social Withdrawal
Cyber Addiction	Hyperactivity	Suicidal Thoughts
Depression	Impulsivity	Thoughts Disorganized
Disorientation	Irritability	Trembling
Distractibility	Loneliness	Unresolved Trauma
Dizziness	Memory Impairment	Worry
Drug Use	Mood Swings	Other
Eating Disorder	Obsessive Thoughts	

Medical/Physical Health

Overall how would you describe your current physical health? _____

List any current health concerns:

_____

_____

Primary Care Physician Name and Phone Number:_____

May I contact your PCP to coordinate your care?_____

Are you currently receiving any other professional counseling or psychiatric treatment? ___Yes ____No

If yes, please provide the following

Name of Provider Reason for Current Treatment

_____ _____

_____ _____

Are/Is the above provider/s aware of your involvement in this treatment? _____Yes _____No

If the provider above is a psychiatrist, are there any medications being prescribed? ____Yes ____No

List all medications you are currently takikng

Current Prescribed Medications	Dose	Frequency	Purpose	Side Effects

Chemical Use History

Have you ever been treated for alcohol and or drug dependence/abuse? ___ Yes ____ No

Have you ever felt that you should cut down on or alcohol and/or drug use? ___Yes ____No

Has a friend or family member ever discussed concerns about your alcohol and /or drug use? ___Yes ____No

Have you felt guilty about your drinking and or drug use? ____Yes _____No

Have you ever received a DUI?____ Yes ____No If yes, when?_____

Have you been arrested on any alcohol or drug related incidents? ____Yes ____No If yes, when?____

Have you engaged in activities that were potentially dangerous as a result of you drinking and or drug use? _____Yes _____No

Are there been any legal issues related to drinking and or drugs? _____Yes _____No

If yes, what have been the issues?

_____
_____

Are there any current legal issues related to drinking and or drugs? _____Yes _____No

If yes, what are the current issues?

_____

_____

Are there any issues at work related to drinking and or drugs? _____Yes _____No

Have you ever experienced any withdrawal symptoms? _____Yes _____No

Have you experienced blackouts? _____Yes _____No

Is there a family history of alcohol and or drug use? _____Yes _____No

If so, whom?_____

Are you currently drinking and or using drugs? _____Yes _____No

Would you say you __are a social drinker __heavy drinker __have alcoholism __have a drinking problem

Or how would you describe your use_____

Would you say you __are a recreational drug user ___have an addiction ____have a drug problem

Or how would you describe your use _____

Please indicate with the letter "P" your primary drug of choice

Drug	Last Use	Amount	How Often	Age First Used
Caffeine				
Tobacco (smoked or chewed)				
Alcohol				
Marijuana/THC				
Cocaine/crack				
Inhalants				
LSD				
Opiates				
Benzodiazapines				
Amphetamines				
Adderall				
Methamphetamine				
Others: Specify				

Family History

Marital Status

Single ____Partnered_____Married_____Separated_____Divorced_____Widowed_____

Name of Spouse or Partner_____ Age_____ How long together_____

Children

_____ Age_____ Living with you Yes____ No_____
_____ Age_____ Living with you Yes____ No_____
_____ Age_____ Living with you Yes____ No_____
_____ Age_____ Living with you Yes____ No_____

Any previous marriages? Yes_____ No_____ Number____

How long were in the marriage_____ Number of years divorced_____

Any Children? Yes No Did/do they live with you? Yes No

Education:

High School _____College_____ (number of years) Vocational _____GED_____

Special Interests or Hobbies

_____

Employment History

Current employment status

_____Full time _____Part time _____Unemployed _____Disabled _____Retired

Current Employer_____

Job Title_____

Length of Employment _____

Any Issues within your current employment ? Yes No

If Yes, are these issues related to you seeking counseling at this time? Yes No

If Yes, briefly describe the current issue

_____
_____

History of Previous Counseling and/or Treatment

Have you had any prior professional counseling or psychiatric treatment? _____ Yes _____ No

Is yes, please list the most recent treatment.

Dates of Treatment	Treatment Provider/ Facility	Reason for treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History/Development

List any pertinent family history of medical probems:

List any family history of mental health problems

List any family history of substance abuse problems

Have you ever been a victim of:

Sexual Abuse? _____Yes _____No If yes, by whom_____

Physical Abuse? _____Yes _____No If yes , by whom_____

Emotional Abuse? _____Yes _____No If yes, by whom_____

Are there any other unusual or traumatic events that have affected you? _____Yes _____No

If yes, please
describe_____
_____
_____

Whom did you live with as a child?
_____
_____

Were there any other issues/ circumstances from your family of origin that has affected you

_____
_____
_____

Counseling Goals

Please list some goals that you would like to achieve in the course of your counseling

_____

_____

_____

Is there anything else that I should know that does not appear on this form that is important?

_____

_____

_____