

## Counseling Intake Form

Name: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone- Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex:       Male       Female      Date of Birth: \_\_\_\_\_

Marital/Relationship Status

- Single (never married)
- Significant other
- Cohabiting
- First marriage
- Separated
- Divorced
- Widowed
- Remarried (after divorce)
- Remarried (after spouse's death)

Current Employment

- Full-time
- Part-time
- Homemaker
- Unemployed
- Full-time student
- Part-time student
- Retired

Annual Household Income

- \$0-9999
- \$10,000-24,999
- \$25,000-49,000
- \$50,000-74,999
- \$75,000+

Children (including, biological, adopted, foster, step)

Name	Sex	Age	Type	Custody
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Education

- Attending/attended high school
- High school degree
- Technical school degree
- Attending/attended college
- College degree
- Attending/attended graduate school
- Graduate degree

Race/Ethnicity

- White
- Black
- Native American
- Asian
- Hispanic
- Multiracial \_\_\_\_\_
- Other \_\_\_\_\_

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Are you presently under a physician's care?  Yes  No

If yes, what for? \_\_\_\_\_

List any medications and amounts: \_\_\_\_\_

Name and address of physician: \_\_\_\_\_

Please check any of the reasons listed below that resulted in your request for counseling:

- |   |   |
|---|---|
| <input type="checkbox"/> Depression or anxiety        | <input type="checkbox"/> Thinking of harming self or others |
| <input type="checkbox"/> Alcohol/drug abuse           | <input type="checkbox"/> Learning difficulties              |
| <input type="checkbox"/> Marital problems             | <input type="checkbox"/> School problems                    |
| <input type="checkbox"/> Communication difficulties   | <input type="checkbox"/> Family counseling                  |
| <input type="checkbox"/> Psychological evaluation     | <input type="checkbox"/> Individual counseling              |
| <input type="checkbox"/> Improve sexual relations     | <input type="checkbox"/> Difficulty with loss or death      |
| <input type="checkbox"/> Child/parent conflict        | <input type="checkbox"/> Relationship enhancement           |
| <input type="checkbox"/> Divorce counseling           | <input type="checkbox"/> Abuse (physical/mental)            |
| <input type="checkbox"/> Sexual orientation questions | <input type="checkbox"/> Pre-marital counseling             |

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern

Frequency

No concern

No occurrence

Little concern

Occurs rarely

Moderate concern

Occurs sometimes

Serious concern

Occurs frequently

Very serious concern

Occurs nearly always

Have you received prior counseling related to any of the above problems?  Yes  No

If yes, was it:  Outpatient  Inpatient

When: \_\_\_\_\_ Where: \_\_\_\_\_

By whom: \_\_\_\_\_ Length of treatment: \_\_\_\_\_

Problems treated: \_\_\_\_\_

Outcome:  Very successful  Somewhat successful  Stayed the same

Somewhat worse  Much worse

Were you referred to this agency?  Yes  No If yes, by whom? \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_