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INDIVIDUAL COUNSELING INTAKE:

TODAY'S DATE:______________

NAME:______________________________DOB:_______ AGE:____GENDER: _____________

SOCIAL SECURITY #______________________

ON SSI(SUPPLEMENTAL SECURITY INCOME)? YES NO

ON SSDI(SOCIAL SECURITY DISABILITY INSURANCE)? YES NO

ADDRESS:____________________________CITY:_____________STATE:_____ZIP_________

PHONE NUMBER:__________________CELL:____________________WORK:_____________

INITIAL HERE__________IF I CAN LEAVE A MESSAGE OR TEXT ON CELL PHONE.

EMAIL ADDRESS:____

MARITAL STATUS: NEVER MARRIED/ MARRIED/ DIVORCED/ WIDOWED

EMPLOYER:_______________________ LENGTH OF EMPLOYMENT:_______________

HOW DID YOU FIND US?:____

VETERAN? YES-NO ACTIVE DUTY? YES-NO

RACE________________

ANY DISABILITIES? DEVELOPMENTAL DEAF BLIND LEARNING TRAUMATIC BRAIN INJURY NONE

DO YOU HAVE AN ADVANCED DIRECTIVE FOR HEALTH CARE? YES-NO

EMERGENCY CONTACT:

NAME:____________________________________RELATIONSHIP________________

ADDRESS:_________________________________PHONE NUMBER:______________

PLEASE INITIAL GIVING ME PERMISSION TO CONTACT IN CASE OF EMERGENCY:________

WHAT BROUGHT YOU TO OUR OFFICE TODAY AND DATE PROBLEM BEGAN:

EDUCATION:

GRADUATE FROM HIGH SCHOOL: YES NO DID YOU GRADUATE FROM COLLEGE? YES NO

LAST GRADE ATTENDED:____________________ HIGHEST DEGREE HELD:____________

FAMILY INFORMATION:

NUMBER OF MARRIAGES AND/OR COHABITATIONS:____________

NAME OF CURRENT SPOUSE/PARTNER:______________________________________
YEARS TOGETHER______________

CURRENT YEARLY FAMILY INCOME_____________ # OF PEOPLE THIS INCOME IS SUPPORTED BY________

CHILDREN
PLEASE PLACE AN "X" NEXT TO THOSE NOT LIVING WITH YOU.
AGES

____ _____ ____ ____ ____ ____ _____

ARE YOU THINKING ABOUT HURTING YOURSELF OR COMMITTING SUICIDE TODAY? YES NO

HAVE YOU EVER ATTEMPTED SUICIDE? YES NO

IF SO WHEN:____

WHATHAPPENED?____

Circle any of the following, which apply to you:

Headaches
Fainting
Dizziness
Memory problems
Irritability
Restlessness
Anxiety
Panic attacks
Racing thoughts
Depression
Fatigue
Frequent worries
Poor appetite
Over eating
Weight change
Vomiting
Insomnia
Excessive sleep
Nightmares

HIV exposure
Hepatitis

Feelings of inferiority
Homicidal ideas
Suicidal ideas
Past suicide attempts
Guilt
Difficulty making decisions
Unwanted thoughts
Brooding
Preoccupations
Compulsions
Heart palpitations
Problems concentrating
Difficulty relaxing
Stomach trouble
Bowel problems
Hallucinations
Problems trusting people
Paranoid thoughts / feelings
Tuberculosis

Alcoholism
Smoke tobacco

Marked mood change
Loneliness
Legal problems
Past court involvement
Employment problems
Inadequate income
Eating disorder
School problems
Problem with anger
Victim of child abuse
Drinking too much
Past drug / alcohol problem
Drug problems
Family problems
Sexual problems
Difficulty making friends
Loss of relationship
Poor church support
Substance Abuse

Do you have any medical conditions I need to be made aware of? Yes No

If yes, please identify and name/phone # of family physician:_______________________________________

Mental Health History:

Have you ever been diagnosed with a mental health disorder? Yes No

If so, what?____

Have you ever sought counselor or therapy for a mental health disorder? Yes No

If so when?____

Where did you go for treatment?____

Are you taking any medication for a mental health disorder? Yes No

If so, what medication, dosage and prescribing physician: