**INTAKE FORM PART I**

Date \_\_\_/\_\_\_/\_\_\_

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact you by email for scheduling purposes? **Y N**

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

**Local Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Can I call you here? (****Yes/No)***

 *Can I leave a message?(****Yes/No****)*

**Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** *Can I call you here?(****Yes/No****)*

*Can I leave a message?(****Yes/No)***

*I typically will not identify myself as calling about counseling when I call, in order to protect your privacy. Due to a variety of factors, sometimes peoples are difficult to reach or never receive messages. Please call me back if you do not hear from me in a reasonable time.*

How did you hear about me?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone urged you to come here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Briefly tell me about the concerns that have brought you here.***

***Please check any current or past issues that still affect you.***

 Eating Disorders  Academic Issues

 Stress/Anxiety  Chronic Pain

 Phobias *(type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)*  Alcohol/Other Drug Use

 Spiritual Concerns  Depression

 Death of a someone close  Pornography

 o *recently (when: \_\_\_\_\_\_\_\_)*   Sexual Identity Issues

o *in the past (when:\_\_\_\_\_\_\_)*  Performance Anxiety/Focus

 Family Issues *(i.e. divorce, alcoholism, domestic violence)*

 Relationship Concerns  Suicidal Thoughts

 o *Family*  Anger Issues

  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

o *Friend*

 o *Parent*

 o *significant other*

 o *roommate*

**INTAKE FORM PART II**

***Your History***

Current medical problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications *(all, including herbal)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Are you currently working with any Personal Physician? Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What for?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been on any medications in the past for mental health issues? **Y N**

*(Please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Have you previously seen a therapist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Who/Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what types of issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a therapist? **Y N**

Nearest Relative, other than Spouse/Partner: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for physical or mental health issues? *(Briefly describe)*

Have you had any previous suicide attempts? *(Briefly describe)*

***If you currently experience any of the following symptoms, please rate them using the key below.***

*Never = 0 Seldom =1 Often = 2 Always = 3*

\_\_\_ Difficulty concentrating \_\_\_ Crying

\_\_\_ Missing classes \_\_\_ Feeling helpless

\_\_\_ Feeling uptight \_\_\_ Worrying

\_\_\_ Feeling hopeless \_\_\_ Feeling afraid

\_\_\_ Lying to others \_\_\_ Feeling out of control

\_\_\_ Feelings of self-doubt \_\_\_ Injuring self

\_\_\_ Nervous around others \_\_\_ Suicidal Thoughts

\_\_\_\_Memory loss or blackout \_\_\_Difficulty sleeping

\_\_\_\_Stealing \_\_\_Anger

\_\_\_\_Eating binges \_\_\_Drinking heavily

\_\_\_\_Other drug use \_\_\_Guilt feelings

\_\_\_\_Withdrawing socially \_\_\_Sexual preoccupation

\_\_\_\_Physical symptoms *(i.e. headaches, digestive)*

*List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Have you seen a health care provider for these?*

Please use the scale below to answer the following questions.

***4=True to a great extent 3=Mostly true 2=Somewhat true 1=Not at all true***

My current concerns affect my success in life. \_\_\_\_\_

My current concerns affect my ability to interact and connect with others. \_\_\_\_\_

I am optimistic that I will be able to make some positive changes as a result of counseling. \_\_