



Counseling Intake Form

Name	_____	Age	_____	Sex	_____	D.O.B	_____
Street Address	_____	Phone (home)	_____				
City, State, Zip	_____	Phone (cell)	_____				
Email address	_____	Phone (work)	_____				

For confidentiality, when and where do you prefer to be reached? _____

Current Marital Status:	Single	Married	Engaged	Separated	Divorced
Emergency Contact:	_____	Phone:	_____	Relationship:	_____

Who referred you/how did you hear about us?	_____	May we thank this person for referral?	_____
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Best method of contact (phone, email, text): _____

May we leave a message on your home or cell phone? _____

What types of counseling are you seeking? (please circle one):

Type	Description	Forms Required
INDIVIDUAL	1-on-1 counseling	1 intake form
COUPLES	Couples counseling	1 intake form per person
FAMILY	2 or more family members	1 intake form per person over 18
PRE-MARITAL	Couples who are preparing for or considering marriage	1 intake form per person
GROUP	Issue specific counseling with other individuals	1 intake form

REASONS FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

Where are your concerns causing the most problems? (please check all that apply)	Work	Marriage	Self	Other
	_____	_____	_____	_____

When did your present concern begin to be a problem for you? _____

Have any concerns about you been identified by others? _____

Please rate the severity of your present concerns:	Mild	Moderate	Severe
	_____	_____	_____



Please indicate which of the following areas are currently problems for you (rate all that apply with 1 being minor complaint to 10 being so significant as to cause problems with daily functioning):

_____ Too much pressure/stress	_____ Feeling manipulated or controlled by others	_____ Delusions
_____ Excessive anxiety or worry	_____ Difficulty making decisions	_____ Spiritual concerns
_____ Feeling lonely	_____ Loss of interest in sexual relationships	_____ Hallucinations
_____ Angry feelings	_____ Feeling sexually attracted to members of your own sex or to someone other than spouse	_____ Inability to concentrate at school/work
_____ Concerns about finances	_____ Concerns about physical health	_____ Crying spells
_____ Feeling “numb” or cut off from emotions	_____ Blackouts or temporary loss of memory	_____ Nightmares
_____ Angry outbursts	_____ Insomnia (trouble sleeping) or hypersomnia (sleeping all the time)	_____ Loss of interest in usual activities/lack of motivation
_____ Excessive fear of specific places/people/objections/situations	_____ Loss of appetite/Increased appetite	_____ Obsessions or compulsions with specific activities
_____ Difficulty making friends	_____ Lacking self-confidence	_____ Inability to control thoughts
_____ Feeling as if you’d be better off dead	_____ Issues with food/weight	_____ Feeling trapped in rooms/buildings
_____ Feeling that people are out to get you	_____ Abuse of alcohol and/or drugs	_____ Hearing voices

MEDICAL/HEALTH INFORMATION:

Rate your current health _____ Good _____ Fair _____ Poor Date of last medical exam: _____

Is your health a concern for you? _____

Name and location of primary care physician: _____

Have you ever seen a psychiatrist? _____ Name and location of psychiatrist: _____

Date of most recent visit: _____ Diagnosis: _____