Counseling Intake Form

This information is confidential

Name: _____ Date: _____

Referred by

☐ **Medical Provider:_____**

☐ **Insurance Provider:_____**

☐ **Friend/Family:_____**

☐ **Fruit of Our Hands Ministries:_____**

☐ **F.I.A.T.M._____**

☐ **Walk-In:_____**

☐ **Other:_____**

Have you had any previous counseling services before?

☐ **Yes**

☐ **No**

If yes, please indicate when are where:

Location: _____

Name of Provider/Therapist: _____

How long was the counseling for?_____

PERSONAL AND SOCIAL HISTORY

MARITAL STATUS (circle one)

Single Engaged Married Separated Divorced Widowed

Name of your spouse/significant other: _____

Length of marriage/domestic partnership: _____

Children: Please list children by sex, name and age.

1._____

2._____

3._____
4._____
5._____
6._____

Explain in detail what brings you in today.

_____
_____
_____
_____
_____
_____
_____

Please list any mental health history in your family, including yourself:

_____
_____
_____
_____
_____

Please list any traumatic events in your childhood and adulthood:

_____
_____
_____
_____

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad

Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

	Never	Rarely	Frequently	Date of last use		Never	Rarely	Frequently	
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat “junk foods”				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don’t like being touched