General Intake Form

Name:____ Birthdate:____________________________

Male OR Female

Address:____

Home phone:____Cell:_______________________________

Which number can I use to contact you? Circle all that apply. Home/Cell

Can I leave a message at this number? Circle one. Yes OR No

Email:____

Emergency contact name and relationship:____

Emergency contact phone number:____

Referral source:_______________________________________

Occupation:____

Presenting problem (be specific as possible: when did it start and how does it affect you?):

____

____

____

____

____

____

Estimate the severity of the problem: Mild_____ Moderate______ Severe______ Very Severe_____

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Medical/Mental Health History

Any Previous Therapy/Counseling: ______

If yes, what type of therapy and how long did you attend? ____
____

Was therapy beneficial to you? Why did you feel it helped/didn't help? _________________________________
____

Are you currently in treatment with any other counselor or psychiatric provider? _____________

Medical Problems (describe):____

History of any hospitalizations (medical and/or psychiatric): ____
____

Name of Primary Care Physician:_______________________Phone:______________________

Name of Psychiatrist (if applicable): ____________________Phone: ______________________

Suicide Information	**Check all that apply**
None: No suicidal thoughts	I have never had thoughts of suicide
Mild: Some thoughts, no plan	I am experiencing these thoughts now I have experienced these thoughts in the past I last experienced this on: Date:____________
Moderate: Some thoughts, vague plan, low levels of lethality	I am experiencing these thoughts now I have experienced these thoughts in the past I last experienced this on: Date:____________
Severe: Significant thoughts, plan is specific, and there is a means to execute the plan	I am experiencing these thoughts now I have experienced these thoughts in the past I last experienced this on: Date:____________

Have you ever actually attempted suicide at any time in your life? Yes / No

If yes, when and describe the circumstances leading up to the attempt as well as follow-up after the attempt:
____
____

Substance Use/Addiction History

Prescription Drug Use (Current names): ____
____

Previous Prescription Drug Use (names): ____
____

Any side effects?____

History of Illegal Drug use? (describe):____

Current Illegal Drug use? (describe): ____

Alcohol use/abuse (describe frequency and reason for use): ____
____

Do you struggle with other addictive behaviors (overeating, constantly working, extreme shopping binges, gambling, sexual acting out, etc)? If yes, please describe. ____
____

Symptom Assessment

Emotional Symptoms – Check those that are most applicable to you within the last 2 weeks

__ anger
__ anxiety
__ extreme mood shifts
__ irritability
__ worrying
__ frustration
__ other ____
__ hopelessness
__ helplessness
__ fears
__ depression
__ apathy
__ lack of emotions
__ feelings of inferiority
__ panicky
__ guilt
__ unable to have a good time

Cognitive Symptoms- Check those that are most applicable to you within the last 2 weeks

__ problems with concentration
__ inattention
__ difficulty making decisions
__ distractibility
__ racing thoughts
__ repeated unwanted thoughts
__ recurring nightmares
__ hallucinations
__ memory problems
__ other ____________________

Physical Symptoms- Check those that are most applicable to you within the last 2 weeks

__ increase or decrease in appetite
__ shaky hands/feet
__ tearfulness/crying spells
__ racing heart rate
__ sweating/chills
__ other ____________________
__ body pain/numbness
__ stomach or intestinal distress
__ frequent or severe headaches
__ muscle tension
__ dizziness/fainting
__ sleep difficulties

Behavioral Symptoms- Check those that are most applicable to you within the last 2 weeks

__ hyperactivity
__ impulsivity
__ binge eating/overeating
__ suicidal gesture/attempt history
__ present suicidal thoughts
__ verbal aggression
__ other________________________________
__ physical aggression
__ social withdrawal
__ induced vomiting
__ self-injury
__ increased alcohol/drug use
__ avoidance of school or job
__ disorganization
__ oppositional/defiant
__ lying/deceitfulness
__ sexual problems
__ financial problems
__ relationship problems