Counseling History and Intake

Name: Last	First	Middle	Age	Birthdate	Male __ Female __

Street Address	City	State	Zip	Home Phone	Cell/Work Phone

Marital Status	Religion	Highest Grade/Diploma/Degree	Veteran?	Social Security Number

Employment History – Present Employer	How Long?	Occupation
Previous Employer	How Long?	Occupation
Previous Employer	How Long?	Occupation

Names of Family Members	Age	Emotional Problems?	Living?	Occupation
Spouse/Partner		No __ Yes __	No __ Yes __	
Mother		No __ Yes __	No __ Yes __	
Father		No __ Yes __	No __ Yes __	

List Children By Name:	Living?	Age	Grade/Occupation/Resides:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Siblings By Name:	Living?	Age	Occupation/Resides Where?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In Case of Emergency - Contact:	Relationship	Most Accessible Phone:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Primary Insurance Coverage (See Insurance Card)	Policyholder's Name	Group Number	Policy Number
Secondary Insurance Coverage	Policyholder's Name	Group Number	Policy Number

Keeping Your Physician Informed: It may be beneficial for your (referring) physician to receive information regarding your assessment results and treatment recommendations. If you want your doctor to be notified of these results and recommendations, you will need to complete the authorization form for the Release of Confidential Information.

Name of Doctor	Address	Phone Number

List Each Medication You Are Taking	Purpose of Medication	Strength and Frequency

Do you drink alcohol or use any non-prescription drugs? ___ Yes ___ No If yes, what do you use? _____

Do you sometimes drink or use drugs more than you had planned? ___ Yes ___ No
Have family or friends ever expressed concern about your drinking or drug use? ___ Yes ___ No
Have you ever been arrested for alcohol or drug related charges? ___ Yes ___ No If yes, what charge? _____
Have you ever been treated (or attended AA/NA) for your drinking or drug use? ___ Yes ___ No
Have you ever had episodes where you were unable to remember what happened while under the influence? ___ Yes ___ No
Have you ever overdosed on drugs (by accident or on purpose)? ___ Yes ___ No

Previous Counseling? When?	Name of Counselor	How was it helpful/not helpful? Mental Health Diagnosis:

What made you decide to come to counseling now?

Who referred you to me?

What would you like to accomplish? Is there something you want to change? Please describe.

What assets will assist you in achieving your goal?

What are the obstacles to achieving your goal?

Who supports your decision to come to counseling?	What else is important for me to know about you?