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****CONFIDENTIAL INTAKE AND HISTORY FORM****

IDENTIFICATION

TODAYS DATE: __________________ DATE OF BIRTH: _______________________

NAME OF PATIENT:______________________ AGE:__________________________________

ADDRESS: ______________________________ HOME PHONE: ________________________

____ CELL/WORK: __________________________

EDUCATION: ___________________________ CURRENTLY EMPLOYED: Y N

OCCUPATION: __________________________ REFERRED BY: ________________________

CURRENT PROBLEM

1. Please briefly describe the major problem for which you are seeking help: ___________________________________

   ____

2. How long have you you had this problem? ____

3. What other problems would you like help with? ____

4. Have you ever seen a counselor of any kind before, and if your answer is yes, who and when?___________________

   ____

5. Please check each of the items below that you have experienced .

- □ difficulty concentrating
- □ confused thoughts
- □ disturbing thoughts
- □ seeing things that aren't there
- □ hearing things
- □ trouble with my memory
- □ distrustful of others
- □ unreasonable fears
- □ people don't understand me
- □ can't get things done
- □ trouble sleeping
- □ loss of appetite
- □ feel sad and blue
- □ feel like I have no control
- □ the future looks grim
- □ feel like harming myself
- □ tire easily and often
- □ feel lonely
- □ don't like myself
- □ feel useless
- □ anxious and tense
- □ physical complaints
- □ headaches
- □ aches and pains
- □ panic attacks
- □ feel angry
- □ feel violent
- □ increased use of alcohol or drugs
- □ poor social life
- □ in trouble with the law
- □ act before thinking
- □ do not assert myself
- □ sexual problems
- □ financial problems
- □ family problems
- □ relationship problems
- □ work problems
- □ marital problems
- □ eating disorder
- □ chronic illness
- □ overweight
- □ other

6. Do you smoke cigarettes? ___No ___Yes, # per day:___ # of years:___

7. Do you drink alcohol? ___No ___Yes, # of days per week:___ # drinks per/week___ # of years ___

8. How is your relationship with your family:____

9. Siblings # of brothers: ___ # of sisters:___ Children: Biological:_____________ Step: _______________

10. Current marital status (check all that apply):

- ☐ Single ☐ Engaged ☐ Living together
- ☐ Never Married ☐ Divorced ☐ Separated
- ☐ Married ☐ Widowed ☐ Other _________________________

Have you previously been married? ☐ No ☐ Yes, # of times: _______

11. Who is your family doctor or primary care physician?

Dr's Name: ____________________Address:____________________________ Phone:______________________

12. Please list any medications that you are currently taking:____

____

____

13. Please describe any current health problems that you have and treatment you are receiving:__________________

____

____

14. Please list any serious illnesses/major injuries that you have had and the age at which they occurred:___________

____

____

15. Have you ever been convicted of a crime? ___No Yes ___, explain: ____________________________________

16. How do you spend your leisure time? ____

____

17. FOR CHILDREN: Please list any developmental delays: ____

____

School Problems:____

____