

# COUNSELING INTAKE FORM

Note: This information is confidential.

## Demographic Information:

Name:

Date:

Date of Birth:

Age:

Phone:

Email:

Mailing Address:

Level of Education:

School:

Part-time Employment:

Emergency Contact Name:

ER Contact Relationship:

Emergency Contact Phone:

How were you referred?

If online, which website?

Have you had counseling before? Yes No

If yes, who was seen, where and when?

How helpful was treatment?

Has there ever been a psychiatric hospitalization? Yes No

Are there any health problems? Yes No

If yes, describe:

Is there any disability? Yes No

If yes, describe:

List any medications that you are currently taking:

## Current Concerns:

What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

**Problems you wish to discuss**  
Check any issues you would like to discuss

Communication _____	Anxiety _____
Anger _____	Academic _____
Depression _____	Alcohol/substance _____
Child abuse _____	
Traumatic event _____	Cutting _____
Problems with _____	
Family of origin _____	Suicidal thoughts _____
	Suicidal attempts _____

**Important Previous Relationships**

Name of ex: \_\_\_\_\_ together from \_\_\_\_\_ to \_\_\_\_\_

Why did the relationship end? \_\_\_\_\_

Name of ex: \_\_\_\_\_ together from \_\_\_\_\_ to \_\_\_\_\_

Why did the relationship end? \_\_\_\_\_

Religious affiliation: \_\_\_\_\_

Do you desire Christian Counseling? \_\_\_\_\_

**Parents**

Name	Age	Lives where	Health	Married/Divorced
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Siblings**

Name	Age	Lives where
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

