Canyon Creek Counseling

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INDIVIDUAL INTAKE FORM

CONTACT INFORMATION

Name _____ Date _____

Date of Birth _____ SS# _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

Address: _____

_____

Email: _____ _____ Referred by: _____

Health Insurance _____ Group _____ Policy # _____
(Please submit card for copying)

Emergency Contact Information:

Name _____ _____ Relationship _____

Telephone Numbers:

Home: _____ Work: _____ Cell: _____

RELATIONSHIP INFORMATION

Employment _____

Legal Status: (Please Circle) Single Married Separated Divorced Widowed

Spouse Name _____ Employment _____ Phone Number _____

Describe your present living arrangement. Please list everyone with whom you live.

Name	Age	Gender	Relationship to you

Please list your marriage(s) or other important significant other relationships

Name	Year Begun - Year Ended	Married?	Children from this relationship and ages

HEALTH BACKGROUND

Have you seen a counselor before? ___Yes ___No

If yes, when? _____ For how long? _____

With whom? _____ What was the primary issue? _____

Have you ever been hospitalized for emotional problems or drug/alcohol treatment? ___Yes ___No

If yes, when? _____ For how long? _____

Where? _____ What was the outcome? _____

What medications are you currently taking for emotional problems?

Drug	Dose	Frequency	Prescribing physician

What medications have you taken in the past for emotional problems?

_____

_____

_____

Primary Care Physician_____ Phone_____

Do you have any chronic medical concerns? ___Yes ___No

If yes, please list: _____

_____

List all allergies, serious illnesses, injuries, surgeries, hospitalizations and any other medical conditions you have had:

_____

_____

_____

List all medications or drugs (legal or illegal) you are currently taking or have taken in the last year:

_____

_____

_____

Additional Information:

_____

_____

_____

_____

_____

CONCERNS

What is the main concern that led you to seek counseling at this time? _____

_____

_____

What stressful events have recently occurred?_____

_____

_____

Please circle all items below that currently apply, and feel free to add any notes or details next to the word.
You may add any other concerns at the bottom of the page.

Abuse (Past or Present)	Divorce	Inferiority feelings	Oversensitivity	Shyness
Alcohol use	Dizziness	Inhibitions	Panic/anxiety attacks	Sleep problems
Anger	Eating Issues	Internet Pornography	Parenting	Startle easily
Anxiety	Education	Irritability	Perfectionism	Stomach problems
Attention Problems	Employment Issues	Legal matters	Pessimism	Stress
Being a parent	Emptiness	Loneliness	Phobias	Suicidal thoughts/ feelings
Binging/ Purging	Failure	Loss of Control	Physical problems	Suspiciousness
Career Choices	Fainting spells	Losses	Problems sleeping	Temper
Change in appetite	Fatigue	Low energy	Relationship problems	Temper problems
Chest pain	Fears	Low frustration tolerance	Recurring/Unwanted thoughts	Tension/Stress
Childhood issues	Feeling inferior	Making decisions	Religious/Spiritual concerns	Time Management
Children	Financial problems	Marital coldness	Restricting food intake	Thoughts of hurting others
Choices I have made	Friendship problems	Marital conflict	Ringing in ears	Threats of violence
Codependence	Gambling	Marital infidelity/affairs	Sadness	Tiredness
Concentrating	Grieving	Marriage	School Problems	Too much sleep
Conflict	Guilt	Medical concerns	Self-control	Trauma
Confusion	Hallucinations	Memory problems	Self-esteem	Tremors
Crying	Harming self	Mood swings	Self-neglect	Unable to relax
Cutting/Burning	Headaches	Motivation	Separation	Unhappiness
Deaths	Health	Negative thoughts	Sexual assault	Using drugs to cope
Debt	Home conditions bad	Nervousness	Sexual concerns	Violence
Decision making	Hopelessness	Nightmares	Sexual conflicts	Weight Loss or Gain
Diminished Pleasure	Impulsiveness	Obsessions	Sexual difficulties	Withdrawal/Isolation
Dependence	Increase appetite	Often using aspirin or painkillers		Work Problems
Depression	Indecision			Worrying

Other Concerns: _____

_____

_____

When did these issues begin? _____

What are your goals for counseling? What would you like to change or improve about your life? _____

_____

_____

_____