Intake Form

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Personal Information

Full Name: ____
Last First Middle

Preferred Name:____________________________ Date of Birth:_______________ Age: ______

Race:_________________________ Ethnicity:____________________ Veteran? Yes No

What is your gender identity? Circle all that apply.

Male Female Transgender M-to-F (Male – to – Female) Transgender F-to-M (Female – to – Male) Nonbinary

What is your sexual identity? Circle all that apply.

Straight Gay/Lesbian Bisexual Queer Questioning Asexual Pansexual

What are your preferred pronouns?____

Local Address: ____
Street Address

____
City State Zip Code

Reason for seeking services: ____

____

____

____

Contact Information

Cell Phone: (____)________________

☐Okay to leave message on voicemail ☐Please do not leave message

☐Okay to receive text message appointment reminders

Email: ____

Emergency Contact:

____

Name/Relationship/Phone Number

Current Household Information

Current Relationship:
Please check all responses that best describe your relationship status:

- ☐ Single (How long?) ____
- ☐ Significant Other (How long?)___________________________________
- ☐ Married (How long?) ____
- ☐ Recent Breakup (When?) ____
- ☐ Spouse/Partner Deceased (When?) _______________________________
- ☐ Separated (When?)____
- ☐ Divorced (When?) ____
- ☐ Other ____

Are you currently or in the last 30 days experienced any of the following symptoms (Check all that apply?)

☐ Sadness
☐ Hopeless/Helpless
☐ Sleep Too Much
☐ Sleep interrupted
☐ Fatigue/No Energy
☐ Poor Memory
☐ No Motivation
☐ Lack of Interest
☐ Thoughts of Dying
☐ Guilt
☐ Feel Worthless
☐ Not Hungry
☐ Prefer Being Alone
☐ Irritable/Angry

☐ Can't Sleep
☐ Too Much Energy
☐ No Need for Sleep
☐ Talk Too Fast
☐ Impulsive
☐ Cannot Concentrate
☐ Restless/Cannot Sit Still
☐ Suspicious
☐ Hearing Things
☐ Seeing Things
☐ Have Special Powers
☐ People Watching Me
☐ People Out to Get Me

☐ Poor verbal skills
☐ Memory problems/issues
☐ Difficulty focusing or learning
☐ Display excessive temper
☐ Exhibit aggressive behaviors
☐ Develop learning disabilities
☐ Demand attention through positive/negative behaviors
☐ Act out in social situations
☐ Imitate abusive/traumatic event
☐ Verbally abusive/aggressive
☐ Scream or cry excessively
☐ Startle easily
☐ Unable to trust others/make friends
☐ Self-blame for traumatic event(s)
☐ Self-injurious behaviors (SIB)
☐ Fear being separated from
☐ Parent/caregiver/guardian
☐ Anxious and fearful and avoidant
☐ Irritability, sadness, and anxious
☐ Act withdrawn/self-isolate
☐ Lack self-confidence
☐ Poor appetite/low weight/digestive problems
☐ Wet the bed or self after being toilet trained/ other regressive bxs
☐ Nightmares/sleep difficulties

☐ Feeling Nervous
☐ Fearful
☐ Panic Attacks
☐ Cannot be in Crowds
☐ Easily Startled
☐ Avoidance
☐ Re-occurring Nightmares
☐ Increased thoughts of death
☐ School refusal

Are you currently take any medications? ☐ **Yes** ☐ **No** ☐ **NA**

If yes, please describe: ____

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____

Is there a family history of mental illness in your family? ☐ **Yes** ☐ **No** ☐ **NA**

If yes, please describe:

____

____

____

________________________________ ________________

Print Client Name **Date**

________________________________ ________________

Client Signature **Date**

________________________________ ________________

Counselor Signature **Date**