COUNSELING INTAKE FORM

All information collected will be held in the strictest of confidence.

Name: _____
Date: _____
Referred by:
MedicalProvider:_____
InsuranceProvider:_____
Friend/Family:_____
Fruit of Our Hands Ministries:_____
F.I.A.T.M._____
Walk-In:_____
Other:_____

Have you had any previous counseling services before?
Yes No If yes, please indicate when, focus of services, and where:
Location:_____
Name of Provider/Therapist:_____
How long was the counseling for?_____

PERSONAL AND SOCIAL HISTORY

MARITAL STATUS (check one)

Single Engaged Married Separated Divorced Widowed

Name of your spouse/significant other:

_____

Length of marriage/domestic partnership: _____

Children (Please list children by name, age and sex):

Name	Age	Sex
_____	____.	___
_____	____.	___
_____	____.	___
_____	____.	___
_____	____.	___
_____	____.	___
_____	____.	___
_____	____.	___

Describe what brings you in today in detail:

_____

_____

_____

_____

Please list any mental health history in your family, including yourself in detail:

_____

_____

_____

_____

Please list any traumatic events in your childhood and adulthood:

_____

_____

_____

_____

Behavior (check any of the following behaviors that apply to you):

Overeating	Suicidal attempts	Can't keep a job	Take drugs
Compulsions	Insomnia	Vomiting	Smoke
Take too many risks	Odd behavior	Withdrawal	
Lack of motivation	Drinking too much	Nervous tics	
Eating problems	Working too hard	Procrastination	
Sleep disturbance	Crying	Impulsive reactions	
Phobic avoidance	Outbursts of temper	Loss of control	
Aggressive behavior	Concentration difficulties		

Feelings (check any of the following feelings that apply to you):

Angry	Guilty	Unhappy	Annoyed	Happy	Bored
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious
Hopeless	Contented	Fearful	Hopeful	Excited	Panicky
Helpless	Optimistic	Energetic	Relaxed	Tense	Envious
Jealous	Sad				

Others:_____

_____

_____

NAME	NEVER	RARELY	FREQUENTLY	DATE OF LAST USE
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens				
Diarrhea				
Compulsive Exercise				
Use Laxatives				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early morning awakening				
Fitful sleep				
Binge / Purge				
Poor appetite				
Eat “junk foods”				
Lack of interest in activities				
High blood pressure				
Allergies				
Constipation				

Physical (check any of the following symptoms that apply to you):

Headaches	Stomach trouble	Skin problems	Dizziness Tics
Dry mouth	Palpitations	Fatigue	Muscle spasms
Twitches	Chest pains	Tension	Back pain
Rapid heart beat	Sexual disturbances	Tremors	Unable to relax
Fainting spells	Blackouts	Bowel disturbances	
Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	
Hearing problems	Don’t like being touched		
Burning/itchy skin			