Professional Counseling Intake

Today's Date: _____

Name: _____ Date of Birth: _____

Have you been here before? ❑ Y ❑ N When? _____ Under what name? _____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred method of contact (please circle one): · Home Phone · Cell Phone · Email

Do you have medical insurance? ·Y ·N If yes, what type: _____

Social Security Number (required for lab services only): _____

Student? ·Y · N Where: _____

Highest Education: _____

Occupation: _____ ·Full Time ·Part Time ·Unemployed ·Dependent

Approximate current annual household income:

❑ $1,000-4,999 ❑ $5,000-9,999 ❑ $10,000-14,999 ❑ $15,000-19,999 ❑ $20,000-29,999 ❑ $30,000-39,999

❑ $40,000-49,999 ❑ $50,000-59,999 ❑ $60,000-69,999 ❑ $70,000-79,999 ❑ $80,000 and above

Marital Status: ❑ Married ❑ Single ❑ Other_____

Ethnic Group: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other _____

Religion / Church _____ ❑ N/A Currently Active? ❑ Y ❑ N

How Did You Hear About Us? Check all that apply: ❑Brochure ❑Friend/Family ❑Print Ad ❑Hope Clinic Staff
❑Hope Clinic Website ❑Google (or other search engine) ❑Facebook ❑Instagram ❑Digital Ad ❑Radio Ad
❑Church ❑School ❑Other ❑Medical Facility ❑Agency

Name of referral source: _____

Are you here: ❑Alone ❑With partner/spouse ·Parent ❑Other _____

Permission to Contact

Please check one: ❑ **I DO** ❑ **DO NOT give** permission to contact me hereafter.

May we leave a confidential message on your voicemail? ❑ Yes ❑ No
May identify ourselves: ❑Yes ❑ No
May send mail to above address: ❑Yes ❑ No

_____ _____
Client Signature Date

Office Only Section

Client Information Reviewed and completed: ❑Yes ❑ No STAFF INITIALS: _____

All information entered into EMR software: ❑Yes ❑ No

Please list any medications you are currently taking: _____

_____

Have you previously received any type of mental health services (counseling, psychiatric services, etc.)

❑ Y ❑ N If yes, when?_____ Reason: _____

Briefly describe why you have come in for counseling: _____

_____

What significant life changes or stressful events have you experienced recently?_____

_____

_____

Who do you consider part of your support system?

❑Spouse/partner ❑family ❑friends ❑church ❑social service agencies

Are you currently in a relationship? ❑ Y ❑ N **If yes, for how long?** _____

Have you ever been physically, emotionally, or sexually harmed? ❑ Y ❑ N

Have you experienced recurrent memories of past traumatic events, dreams or nightmares? ❑ Y ❑ N

Do you have a history of self-harm, cutting, etc.? ❑ Y ❑ N

Total number of Pregnancies (if applicable):_____

Have you ever experienced postpartum depression? ❑ Y ❑ N

Have you ever had a miscarriage or stillbirth? ❑ Y ❑ N If yes, please list approximate:
1)Date_____No. of weeks_____ 2)Date_____No. of weeks_____

Have you ever had an abortion? ❑ Y ❑ N If yes, please list approximate:
1) Date_____Type_____No. of weeks_____ Complications_____
2) Date_____Type_____No. of weeks_____ Complications_____

Check any of the following symptoms you have experienced within the past month:

❑ sadness	❑ relationship difficulties	❑ crying spells	❑ anxiety/worry
❑ panic attacks	❑ no energy	❑ hopelessness	❑ depressed mood
❑ flashbacks	❑ thoughts of suicide	❑ irritability	❑ low self-esteem
❑ sexual difficulties	❑ difficulty concentrating	❑ loss of motivation	❑ phobias
❑ nightmares	❑ increased/decreased sleep	❑ blackouts	❑ no pleasure
❑ hallucinations or delusions	❑ feelings of worthlessness	❑ alcohol/drug dependency	
❑ obsessive thoughts/behaviors	❑ more/less appetite than usual	❑ other problems or concern	
❑ thoughts of harming yourself/someone else			

Family History

Check any which have affected a family member

❑ Alcohol/Substance Abuse	❑ Domestic Violence	❑ Depression	❑ Eating Disorder
❑ Obsessive Compulsive Behaviors Anxiety	❑ Suicide or Attempts	❑ Sexual Abuse	

Emergency Contact

Emergency Contact: _____ Phone # _____