Initial Intake Form

Name _____ Age_____ Birthdate ____

Address _____ Email _____

City _____ State_____ Zip __

Home Phone _____Work Phone _____Cell Phone:_____

Occupation _____ Employer _____

Address _____ City _____ State ____

Zip _____

Do You Smoke?_____How Much?_____Do You Drink?_____ How Much? _____

Do You Take Drugs?_____If yes, what kind? _____How often?___

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? Describe:_____

_____

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe: _____

Any Previous Counseling/Coaching? _____If Yes, Name and Phone Numbers of Therapists:

_____

When and Number of Sessions: _____

What do you Wish to Achieve with Counseling/Coaching (top 3 goals)?

_____

_____

Check Any of the Following That May Apply to You:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Stomach Trouble
- ☐ Bowel Disturbances
- ☐ Always Tired
- ☐ Always Sleepy
- ☐ Unable To Relax
- ☐ Insomnia
- ☐ Inferiority Feelings
- ☐ Feel Tense
- ☐ Feel Panicky
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Depressed
- ☐ Suicidal Ideas
- ☐ Take Tranquilizers
- ☐ Alcoholism
- ☐ Dangerous Drugs
- ☐ Allergy
- ☐ Shy With People
- ☐ Can't Make Friends
- ☐ Afraid Of People
- ☐ Home Conditions Bad
- ☐ Unable To Have A Good Time
- ☐ Always Worried About Something
- ☐ Don't Like Weekends/Vacations
- ☐ Can't Make Decisions
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Gambling

☐ Recurrent Dreams	☐ Asthma	☐ Job Problems
☐ Nightmares	☐ Homosexuality	☐ Can't Keep A Job
☐ Hallucinations	☐ Sexual Problems	☐ Other
☐	☐	☐ _____

Anything else that you feel is important for me to know in your situation?

_____

_____