Insight Wellness & Counseling

Intake Form

Name:_____ Date of Birth: _____

Name of parent/guardian if under 18 years of age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we leave a message? ❑ Yes ❑ No

Cell Phone: _____ May we leave a message? ❑ Yes ❑ No

E-mail: _____

*Email & text correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name & Relationship: _____

Phone: _____ ❑ Cell ❑ Other May we leave a message? ❑ Yes ❑ No

Physical History

General Health (please circle): Very Poor Poor Average Good Very good

Are you now under a doctor's care? ❑ Yes ❑ No

If yes, name of doctor: _____

Reason for doctor's care: _____

Are you taking any medication? ❑ Yes ❑ No

If yes, what kind? _____

Reason for medication: _____ Last medical examination: _____

Have you ever been hospitalized for a physical illness? ❑ Yes ❑ No

If yes, please describe: _____

_____

Any recent major illnesses or surgeries? _____

_____

Any recurrent or chronic conditions? _____

_____

Have you ever been hospitalized for a mental illness? ❑ Yes ❑ No

If yes, describe: _____

_____

Do you smoke tobacco or use nicotine products: ❑ Yes ❑ No

Do you take drugs? ❑ Yes ❑ No

If yes, what kind? _____

Do you drink? ❑ Yes ❑ No

If so, how much? _____

Do you feel you have an addiction or problem with any of the following?

❑ Alcohol ❑ Drugs ❑ Sex ❑ Pornography ❑ Gambling ❑ Video Games ❑ Internet

How would you rate your current sleeping pattern? (please circle)

Very Poor Poor Average Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns: _____

_____

Did you have what you would consider to be a trauma as an adult or as a child? ❑ Yes ❑ No

If yes, describe: _____

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? ❑ Yes ❑ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ❑ Yes ❑ No

If yes, when did you begin experiencing this? _____

_____

Are you currently experiencing any other strong emotions? ❑ Yes ❑ No If yes, please describe:

Have you been treated for emotional disturbances? ❑ Yes ❑ No If yes, describe?

Have you had any thoughts of suicide? ❑ Yes ❑ No If so, when?

Are you having any suicidal thoughts currently? ❑ Yes ❑ No

Are you having any homicidal thoughts currently? ❑ Yes ❑ No

Have you had any previous therapy/counseling? ❑ Yes ❑ No

If yes, describe, when, where, how long, and what for:

Family Systems Information

Is there a family history of any medical or psychiatric diagnosis that would be relevant to your treatment?

Spiritual History

Religious upbringing: Present Affiliation:

Is this an important part of your life? ❑ Yes ❑ No

Why or why not?

Present Situation

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

Please state why you decided to come for counseling/therapy: _____

_____

_____

How long has this been a problem for you? _____

What do you hope to achieve with therapy? _____

_____

_____

_____