ClearWater COUNSELING

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Intake Information

Name: _____ Date of birth: _____

Address - May I send mail to you here? YES NO

Street: _____

City / Sta / Zip _____

Email _____

Phone - May I leave a message at this number?

Work: _____ YES NO

Home: _____ YES NO

Cell: _____ YES NO

Primary care physician's name: _____ Phone: _____

Date of last physical exam: _____

Current psychiatrist's name: _____ Phone: _____

List any health problems and medications you are currently taking:

_____

_____

_____

May I contact your physician/s if necessary? YES NO

Please provide your signature indicating your consent _____

Have you ever seriously contemplated suicide? YES NO If yes, when? _____

Please indicate the current use and frequency of the following substances.

	More than once a day	Once a day	Every 2-3 days	Weekly	Monthly	Yearly or less	Never
Alcohol							
Caffeine							
Nicotine							
Prescription drugs							
Non-prescription drugs							

Have you ever been in therapy before? YES NO Was it a positive experience? YES NO

Please describe your reason for seeking therapy at this time? _____

_____

_____

What do you wish to accomplish through the process of therapy? _____

_____

_____

Are there things that you used to do, or would like to do, but currently don't? _____

_____

_____

Is there anything else you think would be important for me to know about you or your family?

_____

_____

Please circle any of the following that presently concern you. Put an * next to the items that concern you the most.

Assertiveness	Health problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Bedwetting	Confidence	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Education	Divorce	Relaxation	Ambition
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Headaches	Finances	Appetite	School
Unhappiness	Fears	Work	Confusion
Premarital	Food	Self-control	Sadness
In-laws	My past	Guilt	Weight

Do you have any other concerns not listed above, if so what are they? _____

_____

_____

Thank you!