Counseling Intake Form

Note: This information is confidential

Name: _____ Date:_____

Physical Issues:

Check any of the following symptoms that apply to you:

Stomach Trouble	Headaches	Skin Problems	Muscle Spasms
Dizziness	Tics	Dry mouth	Palpitations
Fatigue	Burning/Itchy Skin	Twitches	Chest Pains
Tension	Back Pain	Rapid Heart Beat	Sexual Disturbances
Tremors	Unable to Relax	Fainting Spells	Blackouts
Bowel Disturbances	Hearing Things	Excessive Sweating	Tingling
Watery Eyes	Numbness	Hearing Problems	Visual Disturbances

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How many times a week do you generally exercise_____

What types of exercise do you enjoy? _____

Are you currently experiencing any chronic pain? ____ Yes ____ No

If yes, please describe: _____

How often do you drink alcohol? __ Daily __ Weekly __ Monthly __ Infrequently __ Never

How often do you engage in recreational drug use? Daily Weekly Monthly Occasional Never

Are you currently in a romantic relationship? ___ Yes ___ No

If yes, for how long? _____

On a scale of 1 - 10, how well would you rate your relationship? _____

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

_____

_____

Have you received psychological/psychiatric, or counseling services in the past? Yes No

If yes, what was your concern at the time? _____

If yes, with whom and what was the result? _____

If yes, what diagnosis did you receive?_____

List any psychiatric medications you may have been prescribed_____

_____

*** Family Mental Health History:** (Please check any of the following that apply)

Alcohol/Substance Abuse	Anxiety	Depression	Bi-polar
Domestic Violence	Suicidality	Temper	Obsessive Compulsive
Relational Issues	Child Abuse	Other _____	

Rev. Cindy Stewart, LSC ~ Empowering Counseling One On One
1361 W Euless Blvd #107 Euless, Tx 76040 (817) 345-6354