Foundation Counseling Center

Confidential Intake Form

GENERAL INFORMATION

Date: _____ Referred by: _____

Full name: _____ Name you prefer: _____

Ethnicity:
- ❑ Asian
- ❑ Biracial/bicultural
- ❑ Black/African
- ❑ American
- ❑ Caucasian
- ❑ Hispanic/Latino
- ❑ Other

Sex:
- ❑ Male
- ❑ Female

Date of birth: _____ Age: _____

Street address: _____ Suite/Apartment #: _____

City: _____ State: _____ Zip code: _____ May we send mail here: Yes / No

Home Phone: _____ Can we call you here? Yes / No Message here? Yes / No

Work phone: _____ Can we call you here? Yes / No

Cell phone: _____ Can we call you here? Yes / No Message here? Yes / No

Email: _____ Contact you here? Yes / No

Employer: _____ How long have you been there: _____

Occupation: _____ Average hours worked per week: _____

Highest level of education completed: _____ Are you currently in school? Yes / No

If yes, what level? _____ Degree pursuing: _____

Do you regularly attend a place of worship? Yes / No. If yes, where?

_____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

RELATIONAL INFORMATION

Relationship status:

- ❑ Single
- ❑ Dating
- ❑ Engaged
- ❑ Married
- ❑ Separated
- ❑ Divorced
- ❑ Cohabiting and unmarried
- ❑ Partnered
- ❑ Unsure
- ❑ Widowed

How long have you been in that status? _____

Number of previous marriages for you? _____ For your partner/spouse? _____

Partner's/Spouse's name: _____ Partner's/Spouse's age: _____

Is your partner/spouse supportive of you seeking counseling?

- ❑ Yes
- ❑ No
- ❑ Unsure
- ❑ He/She doesn't know

With whom do you currently live? (*Check all that apply*)

- ❑ Alone
- ❑ Spouse
- ❑ Children
- ❑ Parent(s)
- ❑ Sibling(s)
- ❑ Boyfriend
- ❑ Girlfriend
- ❑ Roommate
- ❑ Other: _____

List your children (including step, adopted, foster, deceased) below:

Name	Sex	Age (or year of death)	Relationship to you	Living with whom?

Have you ever placed a child for adoption? Yes / No If Yes, when? _____

Have you ever had a miscarriage? Yes / No If yes, when? _____

Have you ever had a medical abortion? Yes / No If yes, when? _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who has had a significant effect (positive or negative) upon your life.

Name	Age (or year of death)	Relationship to you (mother, father, sibling,step-relation, etc.)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have any previous counseling, psychiatric treatment, substance abuse treatment, or residential or in-patient care, please list the names of therapists or programs (*use the back of this page, if necessary*)

Therapist/Program Name	Major Issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

_____

_____

_____

Your height: _____ Your weight: _____

How has your weight changed in the last 2-3 months:

- ❑ Little or no change
- ❑ Up _____lbs.
- ❑ Down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Doctor & Name of medication	**Dose**	**Reason for Taking Medication**

Are you presently experiencing any suicidal thoughts?

- ❑ Yes
- ❑ No

Have you experienced them in the past?

- ❑ Yes
- ❑ No

Have you ever attempted suicide?

- ❑ Yes
- ❑ No

If Yes, when and how: _____

_____

Have any of your friends or family members ever committed or attempted suicide?

- ❑ Yes
- ❑ No

If yes, when and who: _____

Are you presently experiencing any thoughts of harming yourself or another person?

- ❑ Yes
- ❑ No

ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

- ❑ Stress
- ❑ Anxiety or worry
- ❑ Panic
- ❑ Depression
- ❑ Crying all the time
- ❑ Lack of motivation
- ❑ Fatigue/Lack of energy
- ❑ Poor appetite or overeating
- ❑ Trouble sleeping
- ❑ Poor concentration
- ❑ Feeling worthless or inferior
- ❑ Feeling hopeless
- ❑ Guilt
- ❑ Death of friend or loved one
- ❑ Grief
- ❑ Chronic pain
- ❑ Physical disability
- ❑ Terminal illness
- ❑ Health concerns
- ❑ Loneliness
- ❑ Fears
- ❑ Shyness
- ❑ Low self-esteem
- ❑ Don't like myself
- ❑ Marital problems
- ❑ Other relational problems
- ❑ Parenting problems
- ❑ Physical abuse
- ❑ Emotional abuse
- ❑ Verbal abuse
- ❑ Sexual abuse
- ❑ Sexual problems
- ❑ Gender identity
- ❑ Anger
- ❑ Aggressive behavior
- ❑ Bad dreams
- ❑ Unwanted memories
- ❑ Loss of control
- ❑ Impulsive behavior
- ❑ Controlling
- ❑ Controlled by others
- ❑ Obsessive thoughts
- ❑ Compulsive behaviors
- ❑ Seeing things others don't see
- ❑ Hearing voices
- ❑ Racing thoughts
- ❑ Eating problems
- ❑ Drug use
- ❑ Alcohol use
- ❑ Pregnancy/Infertility
- ❑ Abortion
- ❑ Legal matters
- ❑ Work stress
- ❑ Career choices
- ❑ Indecisiveness
- ❑ Lack of discipline
- ❑ Financial problems
- ❑ Spiritual apathy
- ❑ Other_____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Minimal Moderate Extreme

|_____|_____|

Please describe why you are coming to counseling *(i.e., what are your presenting problems?)*

_____

_____

_____

Why have you decided to come for counseling now?

_____

_____

_____

What are three things you hope to gain from counseling? How would you know they were accomplished?

_____

_____

_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____