HART COUNSELING SERVICES, PLLC

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Counseling Intake Form

Client Information

Full Name: _____

Preferred name: _____Date of Birth: _____

Residence Address: _____

City/Zip: _____ May I send you mail? Yes ___ No ___

Best Contact number: _____ Can I call you? Yes___No___

Leave a message? Yes___No___ Texting - **limited to scheduling and educational links only** –Yes___No___ Can I email you? Yes___No___

Email Address: _____

Employer/occupation: _____

Are there any limits on contacting you that you wish for me to know?_____

_____

How do you describe your gender identity? _____

Preferred gender pronoun (ex: he, him, she, her, all pronouns)? _____

How do you describe your sexual orientation? _____

How do you describe your racial/ethnic heritage? _____

Married ___ Separated ___ Divorced ___Partnered ___ Single How long? _____

Spouse/Partner's name and age: _____

Children: Yes___No___

Name Age Name Age

_____

_____

_____

_____

Emergency Contact

In the event there is an emergency during my care please contact the following person:
Name: _____(printed) Relationship:_____
Phone Number: _____

Background information:

Family Relationships

Father's Name: _____ Age: ____ (Living or Deceased)

Mother's Name: _____ Age: ____ (Living or Deceased)

Siblings: Yes _____ No _____

Name Age Name Age

_____

_____

_____

_____

Other Significant Persons and/or Relationships:

_____

_____

_____

Health Related Concerns

Rate your health: Very Good _____ Good _____ Average _____ Declining _____ Poor _____

Anything you'd like for me to know about your overall health?

_____

_____

_____

Major Illness (Past or Present):

_____

_____

_____

Surgeries: _____

Injuries: _____

Substance Use History

Do you have concerns about addiction? Yes _____ No _____ Uncertain _____

Do you have concerns about substance use/abuse? Yes _____ No _____ Uncertain _____

Do others in your life have concerns about possible addictive and/or use/abuse issues within your life? Yes _____ No _____ Uncertain _____

How would you describe your use of alcohol and/or drugs?

_____

_____

_____

Please read through the following list let me know what concerns you're having or have had that you want me to know about. In front of each concern that applies, please rate the level to which you find, or found it distressing:

1 (Mild) **2** (Moderate) **3** (Serious) **4** (Severe) **5** (Very Severe)

_____ Relational stress	_____ General physical pain	_____ Problems controlling anger/urges
_____ Family conflict/violence	_____ Hot or cold spells	_____ Very talkative
_____ Divorce	_____ Memory problems	_____ Drawing away from people
_____ Parenting concerns	_____ Sweating	_____ Emotional Issues
_____ Behavioral problems of child	_____ Lightheaded / dizzy	_____ Feeling worthless/hopeless
_____ Runaway child	_____ Loss of appetite	_____ Worry / anxiety
_____ Child needs shelter	_____ Loss of weight	_____ Fear
_____ Hard to make friends	_____ Gain of weight	_____ Nervous / tense
_____ Hard to trust anyone	_____ Upset stomach	_____ Shame
_____ Feel used by people	_____ Shaky / trembling	_____ Sad / depressed
_____ Other relationship issues	_____ Sleep problems / nightmares	_____ Resentment
_____ Sexual problems	_____ Difficulty concentrating	_____ Anger / frustration
_____ Sexual abuse issues	_____ PMS symptoms	_____ Confusion
_____ Sexual offender	_____ Drugs / alcohol	_____ Loneliness / abandonment
_____ Sexual identity questions	_____ See/hear strange things	_____ Guilt
_____ Gender identity questions	_____ Quick change of moods	_____ Jealousy
_____ Physical abuse	_____ Unwelcome thoughts	_____ Feel ignored
_____ Health / physical / illness	_____ Feeling others are out to get me/being watched/talked about	_____ Feel suicidal
_____ Less energy than usual	_____ Panicky	_____ Dwelling on problems
_____ More energy than usual	_____ Financial problems	_____ Lack of interest / enjoyment
_____ Restless /can't sit still	_____ Legal problems	_____ Grief / loss
_____ Problems with my breathing	_____ Difficulty staying focused	_____ Faith / spiritual issues
_____ Other:		

Mental Health Service History

Have you received any prior mental health services? (check all that apply)

_____ Support Group _____ Therapy (_____ group _____ individual _____ couple's)

_____ Medication _____ Inpatient Hospitalization _____ Intensive Outpatient Services

Briefly describe what the experience was like for you? What did you like/not like?

_____

_____

_____

Have you had a mental health diagnosis?

If yes, what is/are the diagnosis/es, medications your taking related to the diagnosis, and, what are your thoughts about the diagnosis?

_____

_____

_____

Do you have concerns or questions about a current, past, or possible diagnosis you'd like to discuss with me? Yes _____ No _____ Uncertain _____

_____

_____

Presenting Concern

Briefly, tell me what brings you to therapy, and what led you to believe this concern was worth exploring in therapy at this time?

_____

_____

_____

_____

_____

_____

How have you managed this concern up to this point? Has anything in particular been helpful?

_____

_____

_____

_____

In what ways do you hope I, as your therapist, can help you?

_____

_____

_____

_____

Referring to the table on the prior page, and the concerns you identified there – please use this space to further explain anything you want me to be aware of that's especially concerning today:

_____

_____

_____

_____

_____

Is there anything else you want me to know?

_____

_____

_____

If applicable:

How did you find me? Referral source: _____

If this person is another professional, may I thank them for the referral? Yes _____ No _____