# Insight Counseling, LLC

## Intake Form

Please provide the following information by filling out this form and bringing it to your first session.

Please note: Information you provide here is protected as confidential information.

Name: _____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Address: _____
(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____ May I leave a message? □ Yes □ No

Cell/Another Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact

Name_____ Phone_____

Relationship_____

Referred by: _____

Areas of concern or problems that bring you to
therapy_____
_____
_____

Goals you would like to address in therapy:

1. (primary goal)_____
2._____
3._____

How will you know when you have reached your goals?
_____

_____

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What have you done in the past that you found helpful?

_____

_____

Are you required by a court of law to receive counseling as part of a legal proceeding? □ Yes □ No

**RELATIONSHIPS**

Your Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced

□ Widowed / How Many years? _____

On a scale of 1-10, how would you rate your relationship (10 high) _____

If you have children, list gender & ages, and/or others present in your household:

_____

_____

Other relationship concerns:

_____

_____

**GENERAL HEALTH INFORMATION**

Rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

List any specific health problems you are currently experiencing:

_____

Current medications and dosage:

_____

Have you had recent blood work done? ____Yes ____No

Were there any concerning results? If so, please describe:

_____

What was your thyroid level? _____

Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

_____

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Have you ever had a head injury or concussion? ____Yes ____No

If yes, when and how did this concussion or head injury occur? _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

**Mental Health Symptom Assessment**

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

| I AM EXPERIENCING... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Frequent worry or tension | | | | | |
| Fear of many things | | | | | |
| Discomfort in social situations | | | | | |
| Feelings of guilt | | | | | |
| Phobias: unusual fears about specific things | | | | | |
| Panic Attacks: Sweating, trembling, shortness of | | | | | |
| breath, heart palpitations | | | | | |
| Recurring, distressing thoughts about a trauma | | | | | |
| “Flashbacks” as if reliving the traumatic event | | | | | |
| Avoiding people/places associated with trauma | | | | | |
| Nightmares about traumatic experience | | | | | |

| I AM Feeling... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Decreased interest in pleasurable activities | | | | | |
| Social Isolation, Loneliness | | | | | |
| Suicidal thoughts | | | | | |
| Bereavement or feeling of loss | | | | | |
| Changes in sleep (too much or not enough) | | | | | |
| Normal daily tasks require more effort | | | | | |
| Sad, hopeless about future | | | | | |
| Excessive feelings of guilt | | | | | |
| Low self-esteem | | | | | |

| I notice... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| I am angry, irritable, hostile | | | | | |
| I feel euphoric, energized and highly optimistic | | | | | |
| I have racing thoughts | | | | | |
| I need less sleep than usual | | | | | |
| I am more talkative | | | | | |
| My moods fluctuate: go up and down | | | | | |
| Sad, hopeless about future | | | | | |

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| I have... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Memory problems or trouble concentrating | | | | | |
| Trouble explaining myself to others | | | | | |
| Problems understanding what others tell me | | | | | |
| Intrusive or strange thoughts | | | | | |
| Obsessive thoughts | | | | | |
| Been hearing voices when alone | | | | | |
| Problems with my speech | | | | | |

| I have... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Risk taking behaviors | | | | | |
| Compulsive or repetitive behaviors | | | | | |
| Been acting without concern for consequence | | | | | |
| Been physically harming myself | | | | | |
| Been violent towards other(s) | | | | | |

| I use the following... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Alcohol | | | | | |
| Marijuana | | | | | |
| Nicotine | | | | | |
| Cocaine | | | | | |
| Opiates | | | | | |
| Sedatives | | | | | |
| Hallucinogens | | | | | |
| Methamphetamine | | | | | |
| Stimulants | | | | | |

| My eating involves... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Restriction of food consumption | | | | | |
| Binging and purging | | | | | |
| Binge eating | | | | | |
| A lot of weight loss or gain | | | | | |

| I Have... | Never | Seldom | Often | Always | For how long? |
|---|---|---|---|---|---|
| Concern about my sexual function | | | | | |
| Discomfort in engaging in sexual activity | | | | | |
| Question about my sexual orientation | | | | | |

Rate (circle) your mood on a 0/10 scale: LOW < 1 2 3 4 5 6 7 8 9 10 >HIGH

Have you previously received any type of mental health services (psychotherapy, couples counseling, psychiatric services, etc.)? ____Yes ____No

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If yes, name of previous therapist/practitioner and dates: _____

_____

Previous psychiatric hospitalizations? _____

Are you currently being prescribed medication for mental health? ____Yes ____No

If yes, please list medication(s): _____

_____

In the past, were you prescribed medication for mental health? ____Yes ____No

If yes, please list medication(s) and provide dates: _____

_____

Have you in the past (or currently) used alternative medications, supplements, or mental health treatments? _____Yes _____No

If yes, please list and provide dates (circle those that you found most helpful):

_____

_____

Have you had any inpatient or outpatient treatment for alcohol or drug use? ____Yes ____No

If yes, please explain: _____

**FAMILY MENTAL HEALTH HISTORY**

In the section below, identify if there is a family history of any of the following: If yes, please indicate the family member's relationship to you in the space provided (father, mother, aunt, etc.).

| | Please Circle | List Family Member(s) |
|---|---|---|
| Alcohol/Substance Abuse | yes / no | _____ |
| Anxiety | yes / no | _____ |
| Depression | yes / no | _____ |
| Domestic Violence | yes / no | _____ |
| Obsessive Compulsive Disorder | yes / no | _____ |
| Other _____ | yes / no | _____ |
| Other_____ | yes / no | _____ |

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Suicide Attempts yes / no _____

ADDITIONAL INFORMATION:

Are you currently employed? Yes No If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there particular stress or problems in your current employment?

_____

Favorite interests, activities or experiences? _____

_____

What ethnicity(s) does client and client's family identify with? _____

Are there any concerns or difficulties that client is experiencing related to ethnicity or culture?_____

Do you consider yourself to be spiritual or religious Yes No If yes, please describe your spirituality, faith or belief (if you would like): _____

_____

What do you consider your greatest strengths? _____

_____

_____

I understand that completion of the above is for informational purposes and does not constitute a contract for services as further therapy concerns are generally addressed during the first appointment. I agree to pay for sessions at the time of the appointment.

_____

Name (Printed) Signature Date