Becky Stroman, M.S., LPC Intern
(Andy Young, Ed.D., NCC, LPC – Supervisor)

Counseling Intake Form

First Name: _____ Last Name: _____
Date of Birth: _____/_____/_____ Age: _____ Sex: Male/Female
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _(_____)_____ Cell Number: _(_____)_____
Email Address:_____

Emergency Contact Information

Who would you like to be notified in the case of an emergency? _____
What relationship is this person to you? _____ Phone Number: _____
Medical Doctor's Name: _____ Phone Number: _____

Employment Information

Are you currently employed? Yes/No If so, where are you employed? _____

Family History

Marital Status: Single, never married_____ Engaged_____ Living together without marriage_____ Separated_____
Divorced_____ Widow(er)_____ Married_____ Spouse's name: _____
Are you happy in your relationship? _____

CHILDREN	AGE	SEX	RELATIONSHIP TO YOU	LIVING IN YOUR HOME?
_____	____	___	_____	_____
_____	____	___	_____	_____
_____	____	___	_____	_____
_____	____	___	_____	_____

Counseling History

Is this your first experience with counseling? Yes/No If not, when did you first seek counseling? _____

For what reasons were you previously in counseling? _____
_____
_____

How successful was previous counseling? _____
_____
_____

What changes have you noticed since you called to make this appointment? _____
_____
_____

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Presenting Issues/Problems

Please circle any of the following life circumstances that you have experienced:

Death of: spouse child father mother sibling(s) grandmother grandfather friend other:_____

Experienced: divorce separation suicide attempt miscarriage abortion financial trouble loss of job

Victim of or involved with: ***Child Abuse:*** physical emotional sexual psychological incest ***Spousal Abuse:*** physical emotional sexual psychological incest ***Other:*** abandonment rape robbery assault another's suicide attempt major illness physical disability prejudice other:_____

Please check all that apply:

Sleeping Problems:	**Eating:**	**Physiological Symptoms:**
___ Falling asleep	___ Loss of appetite	___ Restless
___ Staying asleep	___ Increased appetite	___ Anxious
___ Bad dreams	___ Weight loss	___ Shakes
___ Waking up frequently	___ Weight Gain	___ Headaches
___ Hours of sleep per night?	___ Nausea	Other: _____

Please check all that apply:

___ Apathy	___ Feel tired	___ Irritable
___ Suicidal	___ Withdrawn	___ Distracted
___ Hopeless	___ Poor memory/forgetful	___ Poor judgment
___ Lonely	___ Decreased concentration	___ Impulsive
___ Mood swings	___ Feel sad	___ Perfectionist
___ Low interest	___ Indecisive	Other: _____
___ Feel guilty	___ Angry	Other: _____

Please state briefly why you decided to come to therapy? _____
_____
_____
_____

What you would like to work on in therapy? _____
_____
_____
_____

Is there anything else that you would like me to know before we have our first session? _____
_____
_____

I hereby state that everything I have answered on this form is the truth to the best of my knowledge.

Signature: _____ Date: _____