Susan Strong
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Intake Form

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____
Mailing Address: _____ City: _____ Zip: _____
Email Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Provider: _____ Co-Pay Amount: _____ Self-pay: Y/N
Insured's Identification #: _____ Insured's Group #: _____
Member Name (if different from Client): _____ Member Date of Birth: _____

Name of Nearest Relative: _____ Phone: _____ ROI signed: Y/N
Relationship to Client: _____

Emergency Contact: _____ Phone: _____ ROI signed: Y/N
Emergency Contact: _____ Phone: _____ ROI signed: Y/N

If client is under 18, please provide names and contact information of all adults responsible:
1 _____ Phone: _____ Relationship to Client: _____
2 _____ Phone: _____ Relationship to Client: _____
3 _____ Phone: _____ Relationship to Client: _____

Primary Care Provider (doctor): _____ Phone: _____ Date of Last Physical: _____
Medications (if Applicable): _____
_____
How is your health today?_____

Personal History & Information

Sex: M/F Age:_____ Date of Birth: _____ Place of Birth: _____
Sexual Preference: M/F/BI

Married ___ Single ___ Divorced ___ Widowed ___ Separated ___ Number of Marriages: _____
Number of Children: ___ Number of Stepchildren: ____ Number of Grandchildren: ____
Additional Information: _____
_____

Spiritual Preferences or Beliefs: _____
_____

Cultural Beliefs: _____
_____

Strengths (personal & supports): _____
_____

Weaknesses: _____
_____

Life Challenges (example: job loss, relocation, new to area, recent births, working, going to school, long hours):
_____
_____

Symptoms (example: changes in sleep, appetite, attitude, mood, exercise, problem relationships):
_____
_____

Occupation (past/present): _____
_____
Average Number of Work Hours per Week: _____
Level of Education: _____
Future Educational Goals: _____

Hobbies and/or Recreational Activities: _____
_____
Are you currently participating in them? Y/N
If yes, which ones?_____
_____

Death of family, friends, or pets: Y/N If yes, please explain: _____
_____

Personal History of: Depression: Y/N Anxiety: Y/N Panic Attacks: Y/N Mood Disorder: Y/N Alcohol: Y/N
Drug Use: Y/N If yes, list drugs used (e.g. THC, Meth, Cocaine, or other):_____
_____
Method of use (e.g. smoking, IV, Inhalant) _____
_____
Date of last drug use: _____ Age first used: _____ How Often: _____
_____
Other addictive behaviors: Gambling Y/N Sex Y/N Food Y/N Internet Y/N Porn Y/N Other_____

Do you have thoughts of hurting yourself or others? Y/N If yes, which? _____
If yes, what is the frequency (example: fleeting, often)?_____
_____
Do you have a plan (for hurting self or others)? Y/N If yes, what is your plan?_____
_____

Have you been in counseling previously? Y/N If yes, with whom? _____
Length of time in past counseling? _____
Type of counseling: Individual _____ Couple_____ Family _____ Group _____ Relationship ____
Purpose of the counseling: _____
What did you find helpful? _____
_____
What did you not find helpful? _____
_____

Family History of:

Depression: Y/N Anxiety: Y/N Panic Attacks: Y/N Mood Disorder: Y/N Alcohol: Y/N Drug Use: Y/N
If yes, please explain: _____
Addictive Behaviors: Gambling Y/N Sex Y/N Food Y/N Internet Y/N Porn Y/N Other_____
If yes, please explain: _____
Additional Information: _____

Personal & Private (Please be as honest as possible)

Do you have a personal history of abuse? Y/N If yes, please complete the following section:

Emotional: Y/N If yes, by whom? _____
At what age and for how long? _____
Physical: Y/N If yes, by whom? _____
At what age and for how long? _____
Sexual: Y/N If yes, by whom? _____
At what age and for how long? _____
Neglect: Y/N If yes, by whom? _____
At what age and for how long? _____

Are you currently in an abusive relationship? Y/N
If yes, with whom?_____ For how long? _____
Are you currently abusing someone (children, seniors, pets)? Y/N
If yes, with whom?_____ For how long? _____
Any current self abuse? (example: cutting, pinching, hitting) Y/N
If yes, please explain: _____
_____
Any history of self abuse? Y/N
If yes, please explain: _____
_____
Are you currently in any recovery programs or self help programs? Y/N
If yes, please explain: _____
_____

Why are you seeking counseling at this time? _____
_____
_____
What will be different when you have completed counseling?_____
_____
_____
Any questions for me: _____
_____
_____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____
Susan Strong, MED, LPC, NCC

Thank You for taking the time to fill out this intake form.

Referred by:_____

ROI completed: Y/N
Client chose not to sign ROI: Y/N