a l e t h e a t h o m a s

C O U N S E L I N G

Intake Form

Printed Name_____Date _____

Current Address with zip code_____ Phone _____

Email Address_____ DOB _____

Preferred method of contact: Phone___ Email___ ; PCP Name_____

Emergency Contact Name/Phone Number_____

Insurance Provider _____

Why are you seeking counseling at this time?

What would you like to be different as a result of counseling?

Have you previously suffered from this complaint?
If yes, enter previous therapist(s) seen for complaint, approximate dates, & briefly describe treatment:

Current Symptoms (circle all that apply)

Addiction	Anger	Anxiety	Guilt/Shame
Avoidance	Crying Spells	Depression	Irritability
Fatigue	Feeling Empty	Grief	Mood Swings
Hallucinations	Hopelessness	Impulsivity	Self Harm
Libido Changes	Loss of Interest in Activities	Risky Activity	Unstable Relationships
Panic Attacks	Racing Thoughts	Suspiciousness	_____
Sleep Changes	Suicidal Thoughts	Appetite Issues	_____
Worrying Alot		Excessive Energy	_____

Medical History

Date of last Physical by medical doctor:_____ Exercise Frequency:_____

Exercise Type:

Current physical health status:
poor fair improving good excellent

Previous diagnoses and/or mental health treatment**:**

Family History

Are your parents married? Yes / No happily married indifferent unhappily married

Did your parents divorce? Yes / No If yes, how old were you? _____

Did your parents remarry? Yes / No If yes, how old were you? _____

Who raised you? _____

Where did you grow up? _____

Family member mental conditions:

Treated with medications? Yes / No Medications (if known)

How is your relationship with your mother?

How is your relationship with your father?

Siblings and ages:

Social Media Use:_____ hours per day/week

Platforms of choice: _____

Effect on your mood if any?_____

How would you **describe your family of origin**? (Circle all that apply):

abusive caring family chaotic economically insecure

emotionally distant isolated from other family marked by addiction(s)

neglectful moved around a lot raised by someone other than parents

single parent family stable strict supportive

very close to _____ but not to _____ other _____

Present Situation

Highest degree or diploma in school: _____

Current or prior work if retired: _____

Are you married? Yes / No If yes, specify date of current marriage _____

Are you divorced? Yes / No If yes, specify date of divorce _____

Prior marriages? Yes / No If yes, specify number of marriages _____

How is your relationship with your partner? _____

Do you have children? _____ If yes, how is your relationship with your children? _____

Do you believe in God? Are you involved in any religion/spiritual group?

Have you ever been arrested or involved in a lawsuit? If yes, when and why?

Describe your history of alcohol, tobacco, and drug use:

Alcohol ——	never	rarely	occasional	daily	binge
Tobacco ——	never	rarely	occasional	daily	binge
Marijuana —	never	rarely	occasional	daily	binge
Pain Killers –	never	rarely	occasional	daily	binge

Have you ever used (circle all that apply):

Hallucinogens (LSD)	Heroin	Methamphetamines	Cocaine	Stimulants (pills)
Ecstasy	Methadone	Tranquilizers	_____	

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol or prescription drug abuse? _____ If yes, when?

Do you smoke cigarettes? _____ If yes, how many per day? _____

Do you drink caffeinated beverages? _____ How many per day? _____

Have you ever abused prescription drugs? _____ If yes, which ones?

Strengths: What's going well in my life? (Accomplishments, challenges overcome, etc.)

Additional

Is there anything else you want the counselor to know?