True Course Counseling

Intake Form

Today's Date_____

Name: _____
(Last) (First) (Middle Initial)

Address:_____
(street) (City) (State) (Zip)

Email: _____ May I contact you via email? Y / N

Guardian Email: _____ May I contact you via email? Y / N
(if under 18 years old)

Date of Birth_____/____/_____ Age:_____ Gender:_____

Marital Status: Single Married Divorced Separated Widowed

Race: _____ Ethnicity:_____ Religious preference:_____

Home Phone:(_____)_____ May I leave a message? Y / N

Cell Phone: (_____)_____ May I leave a message? Y / N

Work Phone: (_____)_____ May I leave a message? Y / N

Mom Phone: (_____)_____ May I leave a message? Y / N

Dad Phone: (_____)_____ May I leave a message? Y / N

Educational Background:_____

_____

Place of work (if any): _____ Do you like your job?_____

How many jobs have you held in the past 5 years?_____

Please list others in your family or living with you:

Name	Date of Birth	Relationship to you

Physician's Name: _____ Phone: (_____)_____

Psychiatrist's Name:_____ Phone: (_____)_____

Emergency Contact:_____ Phone: (_____)_____

Circle the following terms that apply to you or any of your family members. Indicate concerns for yourself with an "S" and concerns for you family members with an "F";

Nervousness	Health Problems	Marital Problems	Drug use
Shyness	Stomach Problems	Divorce	Alcohol Use
Anger	Bowel Problems	Separation	Financial Problems
Loneliness	Depression	Affair	Problems with Friends
Frustration	Headaches	Problems w/ ex-partner	Can't Have Fun
Temper	Memory Loss	Stress	Tiredness
Self-Control	Sleeping Problems	Grief	Children
Insecurity	Nightmares	Parenting Problems	Career Choices
Fears	Eating Problems	Relationship Problems	Problem with Parents
Panic Attacks	Suicidal Thoughts	Work Problems	Chronic Pain
Isolation	Lack of Energy	Difficulties in Decision Making	School Problems
Can't Concentrate	No Ambition	Legal Problems	Other:_____ _____

Credit Card information

Type of card; Visa, Mastercard, Discover, other_____

Name on card_____

Card number: _____

Expiration date: _____ CVS code: _____ Zip Code:_____

Please explain any family history of significant health problems including addictive/compulsive behaviors and mental health: _____

_____

_____

Do you have any legal concerns? **Y / N** If yes, what specifically? _____

_____

Are you currently involved, or do you expect to be involved in any court-related matters? **Y / N**
Do you have any concerns about violence or abuse in your family? **Y / N**
What concerns have led you to pursue therapy at this time? _____

_____

_____

Please rate the *severity* of your present concerns on the following scale;

Circle one: Mild Medium Severe Totally Incapacitating

Where did you hear about Us? _____

PERSONAL HEALTH HISTORY

Do you have allergies: **Y / N** List:_____

List any medical or physical problems, hospitalizations and surgeries; include when they were diagnosed

1
2
3
4
5

List all prescription and over-the-counter drugs you are taking including dosage:

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐Sedentary (no exercise) ☐Mild exercise (i.e. climb stairs, walk 3 blocks, golf) ☐Occasional vigorous exercise (i.e. work or recreation, less than 4x/wk for 30 minutes) ☐Regular vigorous exercise (i.e. work or recreation, 4x/wk for 30 minutes)
Diet	**Y / N** Are you dieting? Details: **Y / N** Under physicians direction? Number of meals you eat per day?_____

Caffeine	☐None ☐coffee____per day ☐tea____per day ☐cola____per day
Alcohol	Do you drink alcohol? **Y / N** If yes, what kind?_____ How many per week?_____ Are you concerned about how much you drink? **Y / N** Have you tried to quit and can't? **Y / N** Has anyone ever suggested you stop drinking or slow down your drinking? **Y / N** Have you experienced blackouts? **Y / N** When and how often? Are you prone to "binge" drinking **Y / N** Do you drive after you drink **Y / N**
Tobacco	Do you use tobacco? **Y / N** ☐Cigarettes Pks/day_____ ☐Pipe #/day _____ ☐Chew #/day _____ ☐Cigars #/day _____ or year quit_____
Drugs	Do you currently use recreational drugs? **Y / N** If yes, please list:
Gambling	Have you ever: Gambled in a casino? **Y / N** **How often? _____** Bet on races or sports? **Y / N** **How often? _____** Played cards for money? **Y / N** **How often? _____** Played the lottery? **Y / N** **How often? _____**
Sex	Are you sexually active? **Y / N** Do you have any concerns about your sexual activity, including sexual dysfunction, sexual orientation, birth control, infertility, other? **Y / N**
Personal Safety	Do you have any legal concerns? **Y / N** Do you have a history of any type of abuse? Physical, emotional or neglect? **Y / N** Is there any type of abuse happening now? **Y / N**

Mental Health

Is stress a major problem for you?	**Y / N**
Do you feel depressed?	**Y / N**
Do you panic when stressed?	**Y / N**
Do you have problems with eating or your appetite?	**Y / N**
Do you cry frequently?	**Y / N**
Have you ever attempted suicide?	**Y / N**
Have you ever seriously thought about hurting yourself?	**Y / N**
Do you have trouble sleeping?	**Y / N**
Have you been to a counselor before? Whom?	**Y / N**

Goals for Treatment

What would you like to accomplish in therapy?

_____

_____

_____

_____