Intake Form

The purpose of this form is to gather information about you and your experience prior to the first session.

Today's Date: _____

PERSONAL INFORMATION

CLIENT(S) NAME

_____

Date of Birth _____ Gender _____

Address _____ City, State _____ Zip_____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

May we leave messages on your home and/or cell phone (yes or no)?

_____

May we text your cell phone (yes or no)? _____ ***May we email you (yes or no)?*** _____

Client's relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Emergency contact (include name, relationship and phone number): _____

☐ I agree to allow **Launch Point Counseling** to contact my emergency contact on my behalf in the case of emergency

Referral source (include name and organization if referred): _____

How did you hear about Launch Point Counseling? _____

PRESENTING ISSUES

What is motivating you to seek counseling?

What do you hope to achieve through counseling?

What are some strengths or positive characteristics about you that will help during the counseling process?>

Please indicate if you have experienced any of the following in the past 6 months. If you select any of them, you are welcome to share additional details.

___Anger ___Anxiety ___Behavior Problems ___Changes in Appetite/Eating Habits ___Criminal Activity ___Decreased Energy ___Delusions ___Depressed Mood ___Disruption of Thought Process/Content ___Emotional/Physical/Sexual Trauma ___Excessive Crying ___Family Conflicts	___Grief ___Guilt ___Hallucinations ___Hopelessness ___Hyperactivity ___Impulsiveness ___Interpersonal Conflicts ___Irritability ___Manic ___Mood Swings ___Oppositional ___Panic Attacks	___Paranoia ___Physical Aggression ___School/Work Problems ___Self Abusive Behavior ___Sleep Disturbance ___Somatic Complaints ___Suicidal Thoughts/Attempt ___Weight Gain ___Weight Loss ___Worthlessness ___Other (Specify)

Additional Details:

FAMILY, SOCIAL AND IDENTITY INFORMATION

What is your marital or relationship status? Single_____ Married_____ Widowed_____ Separated_____ Divorced _____

Committed Relationship _____ Open Relationship _____

Who lives in your household? Please include the name and relationship to you.

Describe your current employment status:

Describe your employment history:

Describe your education history:

What do you enjoy doing with your free time?

Who makes up your support network (i.e. family, friends, work colleagues, etc.)?

What cultural, ethnic or racial issues may be relevant to counseling?

What sexual orientation and/or gender identity issues may be relevant to counseling?

What religious or spiritual issues may be relevant to counseling?

HEALTH INFORMATION

Have you previously sought mental health services, substance use treatment or mental health counseling? Please describe below:

Outpatient		Inpatient	
Therapist/Program Name	Date	Hospital	Date

Is there any history of mental health issues in your family? ___Yes ___No
If yes, please describe:

Primary Care Physician: _____ Phone: _____

☐ I agree to allow **Launch Point Counseling** to contact my primary care physician

☐ I do not agree to allow **Launch Point Counseling** to contact my primary care physician

Do you have any current physical health issues? ___Yes ___No
If yes, what are they and are you undergoing any treatment?

Please list any prescribed medication:

Medication	Dosage	Date First Prescribed	Are you consistent in taking it?

Have you ever been hospitalized for a physical health issue?___Yes ___No
If yes, when and for what?

Have you ever had any surgery?___Yes ___No
If yes, when and for what?

How healthy is your diet/food intake?

Have you experienced any sudden weight loss or weight gain in the past 6 months?___Yes ___No

Do you have any allergies?___Yes ___No
If yes, what are they?

Do you exercise?___Yes ___No
If yes, please describe the methods and frequency:

How many hours of sleep do you typically get per night?

Do you have any trouble falling or staying asleep? ___Yes ___No
If yes, please describe:

Do you currently have any issues with alcohol or other drug use?___Yes ___No
If yes, please describe:

Do you have a history of any substance abuse or addiction?___Yes ___No
If yes, please describe:

Have you ever experienced any of the following? ___Yes ___No

- Physical abuse___Yes ___No
- Sexual abuse___Yes ___No
- Rape___Yes ___No
- Incest___Yes ___No
- Gender based violence___Yes ___No

If yes, you are welcome to share additional details.