POSITIVE SELF
CENTER

INTAKE FORM

Please provide the following information by answering all the questions below, and bring with you to your first session. Information provided is protected as confidential information. If participating as a couple, each individual needs to complete this form.

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

Name of Parent/Guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Age: _____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐Widowed

Address: _____
(Street) (Apt.)

_____ _____ _____
(City) (State) (Zip)

Cell Phone: (_____) _____ - _____ May we leave a message or text you? ☐ Yes ☐ No

Home Phone: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Work Phone: (_____) _____ - _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we e-mail you? ☐ Yes ☐ No

Appointment reminder preference: ☐ Email ☐Text ☐Call ☐Email and text ☐ No reminder

We may use email for appointment reminders, news, and updates for the Positive Self Center.
Please initial here to acknowledge that you understand text and e-mail correspondence are not considered to be confidential means of communication: _____

Emergency contact: _____ Relationship: _____

Cell Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Employer (or school/grade) and position of client: _____

Education (last year completed or degree): _____

Insurance Information

(if not using insurance, leave blank)

Insurance Company: _____

Name of insured (if other than the patient): _____

Date of birth of insured (if other than the patient): _____/_____/_____

Enrollee ID: _____ Group Number: _____

Primary Care Physician

Name: _____

Address: _____

Phone: (_____) _____ - _____

May we contact your physician to discuss matters relating to primary care? ☐ Yes ☐ No

Family of Origin

Please list names, and very briefly describe the nature/quality of the relationship.

Mother's Name: _____

Father's Name: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ Widower

Stepmother's Name: _____

Stepfather's Name: _____

List your siblings:

Name: _____ ☐ Male ☐ Female Age: _____ ☐ Half ☐ Step

Name: _____ ☐ Male ☐ Female Age: _____ ☐ Half ☐ Step

Name: _____ ☐ Male ☐ Female Age: _____ ☐ Half ☐ Step

Name: _____ ☐ Male ☐ Female Age: _____ ☐ Half ☐ Step

Family Mental Health History

In the section below, please identify if there is a family history of any of the following. If there is, please indicate the family member's relationship to you in the space provided (e.g. father, mother, maternal grandmother, uncle, etc.).

☐ Alcohol/Substance Abuse _____

☐ Anxiety _____

☐ Depression _____

☐ Domestic Violence _____

☐ Eating Disorders _____

☐ Financial Dysfunction _____

☐ Obesity _____

☐ Obsessive Compulsive Disorder _____

☐ Schizophrenia _____

☐ Suicide Attempts _____

☐ Other, please list: _____

Marriage and Family Information

Spouse: _____ Age: _____ Date of Birth: ____/_____/_____

Spouse's employer and position: _____

Education (last year completed or degree): _____

Date of Marriage: ____/_____/_____ Length of dating relationship: _____

Give brief statement regarding circumstances of meeting and dating: _____

_____

Describe the nature of this relationship: _____

_____

If divorced or widowed/widower, when did this occur: _____

List your children:

Name: _____ ☐ Male ☐ Female Age: _____

Name: _____ ☐ Male ☐ Female Age: _____

Name: _____ ☐ Male ☐ Female Age: _____

Name: _____ ☐ Male ☐ Female Age: _____

Please list any other significant relationships (past or current, positive or negative, does not have to be family) and the nature/quality of the relationship:

_____

_____

_____

_____

_____

General Health

Describe your health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Date of last general physical: _____

Do you have any chronic conditions or have you had any recent surgeries? ☐ Yes ☐ No

If yes, please list: _____

_____

Are you currently taking any medications? ☐ Yes ☐ No

Please list all medications and dosage: _____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list and provide dates: _____

_____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how frequently and how much: _____

Do you currently, or have you in the past, used drugs other than for medical purposes?

☐ Yes ☐ No

If yes, please describe: _____

Have you ever had a severe emotional upset? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any unusual developmental childhood history? _____

_____

How many hours per week do you generally exercise? _____

If you exercise, what types of exercise do you participate in? _____

List any specific sleep issues you are currently having: _____

Have you ever had a head injury, concussion or loss of consciousness? ☐ Yes ☐ No

If yes, please list age(s) and severity, i.e. stiches, concussion, momentary or longer lapse of

consciousness: _____

Emotional Health

Previous counseling or psychiatrist experience (where or with whom and approximately when):

_____

Reason for previous counseling: _____

Was there a diagnosis made? ☐ Yes _____ ☐ No

Please check any of the following words that best describe you now:

☐ Active	☐ Imaginative	☐ Often-blue
☐ Ambitious	☐ Impatient	☐ Persistent
☐ Angry	☐ Impulsive	☐ Quiet
☐ Anxious	☐ Introvert	☐ Regimented
☐ Calm	☐ Kind	☐ Self-confident
☐ Easy-going	☐ Leader	☐ Self-conscious
☐ Excitable	☐ Likeable	☐ Sensitive
☐ Extrovert	☐ Lonely	☐ Serious
☐ Fearful	☐ Moody	☐ Shy
☐ Good-natured	☐ Nervous	☐ Spiritual
☐ Hardworking	☐ Obsessive	☐ Submissive

Please check any issues that you have been experiencing:

☐ Abuse	☐ Deception	☐ Moodiness
☐ Addiction	☐ Depression	☐ Panic Attacks
☐ Anger	☐ Eating Disorder	☐ Rebellion
☐ Anxiety	☐ Envy	☐ Relationships
☐ Apathy	☐ Fear	☐ Sadness
☐ Appetite	☐ Grief	☐ Sex
☐ Bitterness	☐ Guilt	☐ Suicidal thoughts
☐ Blended Family	☐ Health	☐ Suicide attempts
☐ Change in lifestyle	☐ Impotence	☐ Work
☐ Children	☐ In-laws	☐ _____
☐ Chronic Illness	☐ Memory	☐ _____

Briefly answer the following questions:

What brings you to counseling?

How long has this been an issue?

What have you already tried to do about this?

What are the top 3 things you would like to accomplish by coming to counseling?

1. _____

2. _____

3. _____

Why do you want to make these changes?

What do you consider your strengths?

What do you consider your weaknesses?

Do you consider yourself spiritual or religious? If so, briefly describe your faith or beliefs.

Do you have any legal history (arrests, DUI, incarceration, litigations, and approximately when)?

Is there any other information that is important for the counselor to know?

_____ _____ Date: _____
Printed Name of Client Signature of Client

If client is under 18:

_____ _____ Date: _____
Printed Name of Parent/Guardian Signature of Parent/Guardian