New Client Confidential Intake Form

Hopkins Counseling Services
407-706-5875

Confidential intake form

GENERAL INFORMATION

Date: ______________________ Referred by: ____

Full name: ____ Name you prefer: __________________________

Sex: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Prefer not to say

Date of birth:__________________________ Age:__________

Ethnicity: ❑ White ❑ Black ❑ Hispanic ❑ Asian ❑ Middle Eastern/North African
❑ Other: __________________

Street address: ____ Suite/Apartment #: _____________

City: ____ State: ___________ Zip code: ________________
May we send mail here: ❑ Yes ❑ No

Mailing address or Post Office Box: ❑ Same as above

Street address: ____ Suite/Apartment #: _____________

City: ____ State: ___________ Zip code: ________________
May we send mail here: ❑ Yes ❑ No

Home Phone:_________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone:_________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone:__________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Email:____ Contact you here? ❑ Yes ❑ No

Employer:____ How long have you been there:________________

Occupation:____ Average hours worked per week:_______________

Highest level of education completed: ______________________ Are you currently in school? ❑ Yes ❑ No

If Yes, what level? ______________________________ Degree pursuing: ___________________________________

Do you regularly attend a place of worship? ❑ Yes ❑No. If Yes, where? __________________________________

In case of emergency, contact:

Name:________________________________ ___________________ Relationship: __________________________

Home phone: ____________________________________ Cell phone: _____________________________________

RELATIONAL INFORMATION

Current marital status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long?________________________________

Number of previous marriages for you? __________________ For your partner/spouse? __________________

Partner's/Spouse's name:____ Partner's/Spouse's age:___________

Is your partner/spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ He/She doesn't know

With whom do you currently live? (*Check all that apply*)
❑ Alone ❑ Spouse ❑ Children ❑Parent(s) ❑ Sibling(s) ❑ Boyfriend ❑ Girlfriend ❑ Roommate
❑ Other:_____________________________________

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _________________________________

Have you ever had a miscarriage or medical abortion? ❑ Yes ❑ No. If Yes, when? _________________________

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue	Dates

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

____

____

Your height: ____________________ Your weight: ____________________

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _________lbs. ❑ down __________ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how: ____
Have any of your friends or family ever committed or attempted suicide? ❑ Yes ❑ No
If Yes, when and who: ____
Are you presently experiencing any thoughts of harming other person? ❑Yes ❑No

PRESENT ISSUES

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past		Present	Past		Present	Past	
❑	❑	Stress	❑	❑	Fears	❑	❑	Controlled by others
❑	❑	Anxiety or worry	❑	❑	Shyness	❑	❑	Obsessive thoughts
❑	❑	Panic	❑	❑	Low self-esteem	❑	❑	Compulsive behaviors
❑	❑	Depression	❑	❑	Don't like myself	❑	❑	Seeing things others don't see
❑	❑	Crying all the time	❑	❑	Marital problems			
❑	❑	Lack of motivation	❑	❑	Other relational problems	❑	❑	Hearing voices
❑	❑	Fatigue/Lack of energy	❑	❑	Parenting problems	❑	❑	Racing thoughts
❑	❑	Poor appetite or overeating	❑	❑	Physical abuse	❑	❑	Eating problems
❑	❑	Trouble sleeping	❑	❑	Emotional abuse	❑	❑	Drug use
❑	❑	Poor concentration	❑	❑	Verbal abuse	❑	❑	Alcohol use
❑	❑	Feeling worthless or inferior	❑	❑	Sexual abuse	❑	❑	Pregnancy
❑	❑	Feeling hopeless	❑	❑	Sexual problems	❑	❑	Abortion
❑	❑	Guilt	❑	❑	Gender identity	❑	❑	Legal matters
❑	❑	Death of friend or loved one	❑	❑	Anger	❑	❑	Work stress
❑	❑	Grief	❑	❑	Aggressive behavior	❑	❑	Career choices
❑	❑	Chronic pain	❑	❑	Bad dreams	❑	❑	Indecisiveness
❑	❑	Physical disability	❑	❑	Unwanted memories	❑	❑	Lack of discipline
❑		Terminal illness	❑	❑	Loss of control	❑	❑	Financial problems
❑	❑	Health concerns	❑	❑	Impulsive behavior	❑	❑	Spiritual apathy
❑	❑	Loneliness	❑	❑	Controlling	❑	❑	Other______________

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Minimally Distressing	Moderately Distressing	Extremely Distressing

Please describe why you are coming to counseling *(i.e., What are your issues, problems?)*: ____________________

____

Why have you decided to come for counseling now? ____

____

What do you hope to gain or change by coming for counseling? ____

____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged a fee for service.

Signed: ____ Date: ____________________