ALDERMAN COUNSELING

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CONFIDENTIAL INTAKE FORM

Full Name: _____ Date: _____

GENERAL INFORMATION

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth ____/____/_____

Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other Sex: [ ] Male [ ] Female

Email Address: _____

Phone (mobile): _____ May we contact you here? [ ] Yes [ ] No

Phone (home): _____ May we contact you here? [ ] Yes [ ] No

Phone (work): _____ May we contact you here? [ ] Yes [ ] No

May we leave a message for you? [ ] Yes [ ] No May we text you? [ ] Yes [ ] No

Preferred method of appointment reminder *(pick one)*:

[ ] Email [ ] Text to Mobile [ ] Phone: *Mobile? [ ] Home? [ ] or Work? [ ]*

Occupation: _____ Place of Employment/School: _____

Education Level: [ ] High School; [ ] Some College; [ ] Bachelors Degree; [ ] Graduate School

Hours worked per week: _____ Estimated annual income: _____

How did you hear about us? [ ] Internet [ ] Physician [ ] Friend [ ] Parent [ ] Other: _____

May we thank them for referring you? [ ] Yes [ ] No

What type of counseling are you seeking? *Please choose one and note Forms Required.*

Type	Description	Forms Required
[ ] Individual	One-on-One Counseling	1 Intake Form per person
[ ] Family	Two or more family members	1 Intake Form per person over 18 yrs.
[ ] Relationship	Dating couples	1 Intake Form per person (2 total)
[ ] Pre-Marital	Engaged couples or those considering marriage	1 Intake Form per person (2 total)
[ ] Marital	Couples needing marital guidance	1 Intake Form per person (2 total)

RELATIONAL INFORMATION

Current relational status: [ ] Single [ ] Dating [ ] Engaged [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Are you content with your current relational status: [ ] Yes [ ] No

If married, how long: _____ Number of marriages for you: _____ For your partner: _____

If separated or divorced, how long: _____ If widowed, how long: _____

Partner's Name: [] Mr. [] Mrs. [] Ms. [] Miss [] Dr. [] Rev. _____

How long have you known your partner: _____ Their age: _____ Preferred name: _____ _____

Partner's Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other Partner's sex: [ ] Male [ ] Female

Partner's Occupation: _____ Hours worked per week: _____ _____

Partner's Education Level: [ ] High school [ ] Some college [ ] Bachelors degree [ ] Graduate school

What words would you use to describe your partner?

_____

Is your partner supportive of you seeking counseling? [ ] Yes [ ] No [ ] Unsure [ ] Partner doesn't know

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

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

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, stepfamily 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**	**Describe this person.**

PHYSIOLOGICAL INFORMATION

Describe your current health: [ ] Good [ ] Fair [ ] Poor Date of your last physical exam: ____/____/_____

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

_____

Check any of the following symptoms/sensations that apply to you presently, or in the recent past:

Headaches	[] Past [] Present	Dizziness	[] Past [] Present	Stomach Trouble	[] Past [] Present
Visual Trouble	[] Past [] Present	Sleep Trouble	[] Past [] Present	Trouble Relaxing	[] Past [] Present
Weakness	[] Past [] Present	Tension	[] Past [] Present	Rapid Heart Rate	[] Past [] Present
Difficulty Breathing	[] Past [] Present	Intestinal Trouble	[] Past [] Present	Hearing Noises	[] Past [] Present
Change in Appetite	[] Past [] Present	Tiredness	[] Past [] Present	Pain	[] Past [] Present
Hearing Voices	[] Past [] Present	Seeing Things	[] Past [] Present	Other	[] Past [] Present

Height: _____ Weight: _____ Weight change in the last 2-3 months: _____ _____

List all current medications you are taking, including those you seldom use or take only as needed:

Name of Medication(s)	Dosage	Reason for taking

Are you presently experiencing 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 friends or family committed suicide? [ ] Yes [ ] No If yes, when and how? _____ _____

Are you presently experiencing any thoughts of harming another person? [ ] Yes [ ] No

COUNSELING HISTORY

List names of previous counselors, therapists, or mental health programs, including dates and contact information:

_____

_____

_____

_____

How do you feel about the results of your previous counseling?

_____

_____

Do we have permission to contact your previous counselor(s)? [ ] Yes [ ] No

Have you ever been hospitalized for psychiatric purposes? [ ] Yes [ ] No

If yes, please explain including name of hospital, location, and dates:

_____

_____

SPIRITUAL BACKGROUND *(optional)*

Do you believe in God? [ ] Yes [ ] NoReligious preference: _____

Which church do you currently attend? _____

How much influence does your faith have on your day-to-day activity? [ ] Very little [ ] Some [ ] A lot

REASON FOR SEEKING HELP

What concerns have led you to pursue counseling?

_____

_____

Where are your concerns causing the most problems for you? *Check all that apply.*

[ ] Home [ ] Work [ ] Marriage [ ] God [ ] Other Relationships (specify): _____

When did your present concern begin to become a problem for you? _____

_____

_____

Check any of symptoms or problems that you are currently experiencing. *Check all that apply.*

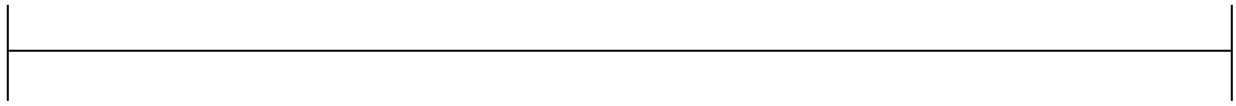
[ ] Stress	[ ] Panic	[ ] Crying all the time
[ ] Anxiety or worry	[ ] Depression	[ ] Lack of motivation
[ ] Fatigue/Lack of energy	[ ] Marital Problems	[ ] Compulsive behaviors
[ ] Poor appetite or overeating	[ ] Other relational problems	[ ] Seeing things others don't see

[ ] Trouble sleeping	[ ] Parenting problems	[ ] Poor concentration
[ ] Physical abuse	[ ] Hearing voices	[ ] Racing thoughts
[ ] Feeling worthless or inferior	[ ] Emotional abuse	[ ] Feeling hopeless
[ ] Verbal abuse	[ ] Eating problems	[ ] Guilt
[ ] Sexual abuse	[ ] Drug use	[ ] Death of friend or loved one
[ ] Sexual problems	[ ] Alcohol abuse	[ ] Grief
[ ] Gender Identity	[ ] Pregnancy	[ ] Chronic Pain
[ ] Anger	[ ] Abortion	[ ] Physical disability
[ ] Aggressive behavior	[ ] Legal Matters	[ ] Terminal illness
[ ] Bad dreams	[ ] Work Stress	[ ] Health concerns
[ ] Unwanted memories	[ ] Career choices	[ ] Loneliness
[ ] Loss of control	[ ] Indecisiveness	[ ] Fears
[ ] Impulsive behavior	[ ] Lack of discipline	[ ] Shyness
[ ] Controlling	[ ] Financial Problems	[ ] Low self esteem
[ ] Controlled by others	[ ] Spiritual apathy	[ ] Don't like myself
[ ] Obsessive thoughts	[ ] Other: _____	[ ] Other: _____

Have any concerns about you been identified by others?

_____

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



Minimally Distressing *Moderately Distressing* *Extremely Distressing*

What do you hope to gain or change by coming to counseling at this time?

_____

_____

TERMS OF SERVICE

I have read, understand, and signed the following documents. I understand that Alderman Counseling (Sc) cannot treat me if I have not read and signed the following.

[ ] **CONSENT FOR TREATMENT**
[ ] **FEE AGREEMENT**
[ ] **NOTICE OF PRIVACY PRACTICES**

Signed: _____ Date: _____