Emotional Wellness Counseling PLLC
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INTAKE

Your cooperation in providing the following information will be very helpful in planning services. Please complete all items as they relate to you or to who will be receiving services. Please ask for assistance if you have questions about any item. Thank you.

Date: _____/_____/_____

Name: _____

Address: _____

City: _____State:_____ Zip Code: _____

Cell Phone: _____ Home Phone: _____Work Phone _____

Date of Birth: _____ Female ( ) Male ( ) Nonbinary ( ) Other ( )

Education: _____

Social Security Number: _____

Place of Employment: _____

Name of Spouse if married: _____

Employment of Spouse if married: _____

Who referred you? _____

Do you have insurance: Yes ( ) No ( ) If yes, please complete:

Insurance Company: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Group Policy Number: _____ID number: _____

Phone Number of Insurance Company: _____

What is the problem that has brought you to counseling?

_____
_____
_____

How long has this been a problem?

_____
_____
_____

How is this problem affecting your life?

_____
_____
_____

Please list the persons living in your household:

_____
_____
_____

Have you ever had any work, school, financial or relationship problems related to drinking alcohol or using drugs? Yes or No

Please rate your work: Stress free ( ) somewhat stressful ( ) Stressful ( ) Very stressful ( )

Job Satisfaction: Satisfied ( ) somewhat satisfied ( ) Dissatisfied ( ) Miserable ( )

Relationship if applicable: Satisfied ( ) somewhat satisfied ( ) Dissatisfied ( ) Miserable ( )

What do you do for recreation or leisure?

_____
_____
_____

Who is your Primary Care Physician? _____

Have you ever had previous counseling? Yes ( ) No ( )

If yes, please indicate when and where:

_____

Have you ever been hospitalized for mental health or substance abuse problems? Yes ( ) No ( )

If yes, please indicate when and where:

_____

Are you taking medication? Yes ( ) No ( )

If yes, please list names and dosages:

_____
_____
_____

Please check any of the following which apply to you:

Domestic Violence/Intimate Partner Violence ( ) Rape/Sexual assault ( )

Sexual harassment ( ) Gender Concerns/Affirmations ( )

Have you ever attempted suicide: Yes ( ) No ( )

Have you ever had thoughts of suicide? Yes ( ) No ( )

Do you have current thoughts of suicide? Yes ( ) No ( )

If yes, what is your plan? _____

Please circle any of the following symptoms you have experienced in the last month.

Depression Hopeless Obsessions/Compulsions Sadness No energy

Trouble concentrating Change in sleep habits Memory problems easily irritated

Change in eating habits Weight changes Stress Tearful Self-esteem problems

Change in sexual interest or function Fear Hurt Frustration Guilt Anxiety

Conflict issues in relationships at home Conflict issues in relationships at work

Anger Violence Impulsive Panic Hearing voices Visual hallucinations

Sexual acting out Mood swings Father Hunger Mother Hunger Divorce

Cutting/Self harm Paranoia Runaway/Risky behavior Rule-hater Grief/Loss

_____
(Print your name)

_____ _____
(Sign your name) (Date)