Foothills Health & Wellness Center

COUNSELOR INTAKE FORM

Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Primary Care Provider: _____

Other Providers involved in your care: _____

Who were you referred by? _____

What are the problem(s) for which you are seeking services?

1. _____
2. _____
3. _____

Medications currently taking: (or provide list)

_____ _____

_____ _____

_____ _____

_____ _____

Symptom Checklist: What problems are you having? Please check all that apply.

_____ Depressed mood
_____ Unable to enjoy activities
_____ Sleep disturbances
_____ Loss of interest
_____ Concentration/forgetfulness
_____ Guilt
_____ Fatigue/low energy
_____ Decreased libido
_____ Racking thoughts
_____ Impulsivity
_____ Risky behaviors
_____ Hearing voices when no one else is present
_____ Dependency on others
_____ Self-harm or cutting
_____ Nightmares
_____ Thoughts of killing yourself
_____ Withdrawing from other people
_____ Relationship problems
_____ Gambling

_____ Difficulty leaving your home
_____ Excessive energy
_____ Decreased need to sleep
_____ Irritability
_____ Excessive worry
_____ Anxiety/panic attacks
_____ Unusual visual experiences
_____ Suspiciousness
_____ Rapid mood changes
_____ Repetitive or compulsive behaviors
_____ Fear of certain objects or situation
_____ Outbursts of anger or fights
_____ Feeling worthless
_____ Feeling Hopeless
_____ Loneliness/lack of social support
_____ Parenting problems
_____ Work/school problems
_____ Instructive thoughts or memories
_____ Feeling confused as to what is real & unreal

Other: _____

_____

Foothills Health & Wellness Center

Mental Health History: What conditions have you been diagnosed with previously?

_____ Depression
_____ Bipolar disorder
____ Type 1, ____ Type 2
_____ Post-traumatic stress disorder (PTSD)
_____ Anxiety
_____ Panic disorder
_____ Adjustment disorder
_____ Dysthymia
_____ Schizophrenia
_____ Schizoaffective disorder
_____ ADHD/ADD
_____ Phobia(s)_____

_____ Substance use disorder
_____ Alcoholism
_____ Personality disorder _____
_____ Body dysmorphic disorder
_____ Eating disorder
_____ Obsessive compulsive disorder (OCD)
_____ Learning disability
_____ Postpartum depression
_____ Psychosis
_____ Paranoia
_____ Dementia or cognitive disorder
_____ Other: _____

Have you been on medication to treat any of these issues? ☐ Currently ☐ Not now but in the past ☐ No

Have you been admitted to a psychiatric hospital before? ☐ Yes ☐ No

Have you attempted to kill yourself before? ☐ Yes ☐ No

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before? ☐ Yes ☐ No

Who/Where/When? _____ -_____

What are you most concerned about right now? _____

Social / Habits:

	Yes	No
Do you have a safe and/or stable place to live?		
Have you been incarcerated?		
Do you currently have legal problems?		
Have you been arrested?		
Do you see your children exhibiting high risk		
Has social services been involved with your family?		

Work status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Committed relationship ☐ Divorced ☐ Separated ☐ Widowed

How many times have you been married? _____ How many children and ages? _____

Education-- Highest grade level completed? _____

Did you serve in the military? ☐ Yes ☐ No Branch: _____

Do you have a religious affiliation ☐ Yes ☐ No Type: _____

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How often do you drink alcohol? _____ ☐ Never

Tobacco use: ☐ Never ☐ Current ☐ Quit Type: ☐ Chew ☐ Smoke

Do you use recreational drugs? ☐ Yes ☐ No

What kind? _____ How often? _____

Do you exercise? ☐ Yes ☐ No What do you do and how often? _____

Do you have an Advanced Directive such as a power of attorney or living will? ☐ Yes ☐ No

Do you have or need help managing your affairs? ☐ Yes ☐ No

Have you been the victim of any abuse or violence? ☐ Yes ☐ No

Family History:

☐ Adopted ☐ Unknown

Do you have immediate family members with mental or emotional problems? ☐ Yes ☐ No

Who: _____ What issues? _____

Who: _____ What issues? _____

Who: _____ What issues? _____

Emergency Contract Info:

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone or Cell Number: _____

Relationship to you: _____

THANK YOU!!