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	_____	Difficulty leaving your home
_____	Unable to enjoy activities	_____	Excessive energy
_____	Sleep disturbances	_____	Decreased need to sleep
_____	Loss of interest	_____	Irritability
_____	Concentration/forgetfulness	_____	Excessive worry
_____	Guilt	_____	Anxiety/panic attacks
_____	Fatigue/low energy	_____	Unusual visual experiences
_____	Decreased libido	_____	Suspiciousness
_____	Racking thoughts	_____	Rapid mood changes
_____	Impulsivity	_____	Repetitive or compulsive behaviors
_____	Risky behaviors	_____	Fear of certain objects or situation
_____	Hearing voices when no one else is present	_____	Outbursts of anger or fights
_____	Dependency on others	_____	Feeling worthless
_____	Self-harm or cutting	_____	Feeling Hopeless
_____	Nightmares	_____	Loneliness/lack of social support
_____	Thoughts of killing yourself	_____	Parenting problems
_____	Withdrawing from other people	_____	Work/school problems
_____	Relationship problems	_____	Instructive thoughts or memories
_____	Gambling	_____	Feeling confused as to what is real & unreal

Other: _____

_____

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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!!