

Good Counsel Intake Form

The following information is needed to best help you. Please print your responses clearly.
Gray boxed areas, or areas you cannot answer, are to be completed by/with your counselor.
Case records are strictly confidential.

SECTION I: IDENTIFYING INFORMATION

Today's Date ____/____/____ Assigned Counselor: _____

Contact First Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Phone: Please check preferred contact phone number.

Home _____ Work _____ Cell _____

E-mail Address _____

Date of Birth _____ Age _____ Gender: F M Ethnicity _____

Single Engaged Married Divorced Separated Years Married? ____ No. of Children ____

Family Members Currently Living In Home		
Full Name	Relationship	Age

Employer _____ Salary _____

Spouse, Child or Person in Counseling with Client (if applicable)

First Name _____ Last Name _____

Date of Birth _____ Age _____ Ethnicity _____

Employer _____ Salary _____

Emergency Information

Name _____ Relationship _____ Phone _____

Church Home: _____ City _____

Attendance: Weekly 2x/Month Monthly Other _____

How did you hear about Good Counsel? _____

Therapist Preference: Male Female No Preference Name _____

Payment Structure: Self Paid Church Partnership Insurance _____

Hourly Session Fee: \$ _____ Method: Cash Check Credit Card

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Good Counsel

OFFICE LOCATION: 13701 W. Jewell Ave., Ste 200, #10, Lakewood, Colorado 80228 720.295.2827 1

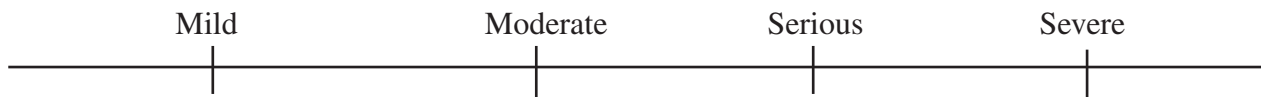
SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Why did you decide to seek counseling: _____

What you want to work on while in counseling: _____

How long has this been a significant problem for you? Please be specific (i.e., not “all my life”). _____

How would you estimate the severity of the problem at this time? (Place “X” on the line below)



What symptoms are you experiencing as a result of this problem? Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> overeating | <input type="checkbox"/> vomiting | <input type="checkbox"/> easily distracted |
| <input type="checkbox"/> restless | <input type="checkbox"/> recent weight loss | <input type="checkbox"/> fatigue/loss of energy |
| <input type="checkbox"/> rapid heart rate | <input type="checkbox"/> low motivation | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> compulsive behaviors | <input type="checkbox"/> muscle tension | <input type="checkbox"/> sleeping patterns |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> distrust | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> depressed mood | <input type="checkbox"/> appetite changes | <input type="checkbox"/> problems with work |
| <input type="checkbox"/> sweating | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> housing problems |
| <input type="checkbox"/> fears/phobias | <input type="checkbox"/> outbursts of temper | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> odd behavior/thoughts | <input type="checkbox"/> jumpy | <input type="checkbox"/> drinking alcohol |
| <input type="checkbox"/> crying | <input type="checkbox"/> social withdrawal | <input type="checkbox"/> financial problems |
| <input type="checkbox"/> trembling or shaking | <input type="checkbox"/> feeling of worthlessness | <input type="checkbox"/> pain |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> nightmares | <input type="checkbox"/> self-mutilation behaviors |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> dizzy or lightheaded | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> difficulty concentrating | <input type="checkbox"/> emotional problems | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> stomach problems | <input type="checkbox"/> other: _____ |

SECTION III: MEDICAL HISTORY

Name of Physician _____ Date of last physical exam: _____

Phone _____ Location of office _____

List any significant past or current health, medical, or psychiatric issues:

Dates	Problem	Treatment	Hospitalized? (Y/N)

Have you ever had treatment by, or are you currently seeing, a psychiatrist, psychologist, therapist, or counselor? Yes ___ No ___

Dates	Problem	Therapist	Helpful? (Y/N)

Have you ever been given a mental health diagnosis in the past from a mental health professional?

Yes ___ No ___ If yes, as you understand it, what is/was that diagnosis? _____

Have you ever been admitted into a mental health care facility? Yes ___ No ___

Dates	Name and Location of Facility

Have you ever attempted suicide? Yes ___ No ___ If yes, please explain.

Have any family members ever attempted suicide? Yes ___ No ___ If yes, please explain.

SECTION IV: MEDICATIONS AND SUBSTANCES

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	How Long Taken?	Prescribing Physician	Helpful (Y/N)

Substance Intake (if applicable)

Please list amount of daily **or** weekly (D/W) consumption of the following:

Coffee ____/____ Soda ____/____ Tea ____/____ Cigarettes ____/____

Alcohol ____/____ Type: _____ Illegal Substance ____/____ Type: _____

Do you use any of these substances to (check all that apply):

- Manage Stress To Relax To Change Mood For Sleep

SECTION V: FAMILY OF ORIGIN INFORMATION

Family Members: Include Blended Family Members

Name	Age	Relationship	Deceased (Y/N)

Have any members of your family had problems with:

	Name	Relationship	Deceased (Y/N)
Drugs/Alcohol			
Depression			
Anxiety			
Mental Problems			
Physical Illness			

Who do you rely on for support: _____ Relationship _____

NOTE: There is room on the following page to tell us what else we should know to give you the best care.

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