



## Intake Form

*Information you provide here is **protected as confidential information.***

*Please fill out this form and bring it to your first session.*

Client's Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

\_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_

Single  Partnered/Married  Separated  Divorced  Widowed

Children (names and DOB): \_\_\_\_\_

Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) May we leave a message?  Yes  No

Cell/Other Phone: ( ) May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Insurance Carrier: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Social Security Number of Responsible Party: \_\_\_\_\_

Who referred you to Aspen Grove Counseling or how did you hear about us?:

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No

Yes, previous therapist/practitioner: \_\_\_\_\_

Are you currently taking any prescription medication?

Yes

No

Please list:

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Have you ever been prescribed psychiatric medication?

Yes

No

Please list and provide dates:

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#### GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor            Unsatisfactory            Satisfactory            Good            Very good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (please circle)

Poor            Unsatisfactory            Satisfactory            Good            Very good

Please list any specific sleep problems you are currently experiencing:

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3. How many times per week do you generally exercise? \_\_\_\_\_

What types of exercise do you participate in: \_\_\_\_\_

4. Please list any difficulties you experience with your appetite or eating patterns.

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5. Are you currently experiencing overwhelming sadness, grief or depression?

No  Yes

If yes, for approximately how long? \_\_\_\_\_

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

No  Yes

If yes, when did you begin experiencing this? \_\_\_\_\_

7. Are you currently experiencing any chronic pain?

No  Yes

If yes, please describe? \_\_\_\_\_

8. Do you drink alcohol more than once a week?  No  Yes

9. How often do you engage recreational drug use?  Daily  Weekly  Monthly

Infrequently  Never

10. Are you currently in a romantic relationship?  No  Yes

If yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_\_

11. What significant life changes or stressful events have you experienced recently:

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12. Are you currently employed?  No  Yes

If yes, what is your current employment situation:

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Do you enjoy your work? Is there anything stressful about your current work?

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13. Do you consider yourself to be spiritual or religious?  No  Yes

If yes, describe your faith or belief:

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14. What would you like to accomplish out of your time in therapy?

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