

INTAKE FORM

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Donald Ford Counseling, LLC

Please provide the following information by filling out this form and bringing it to your first session. (To give the Therapist extra time to review, mail to the listed office address in advance of your appointment).

Please note: information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

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.

Referred by : _____

Areas of concern or problems that bring you to Therapy: _____

GOALS you would like to address in Therapy:

1. (primary goal) _____

2. _____

3. _____

How will you know when you reached your goals? _____

What have you done in the past that you found helpful? _____

RELATIONSHIPS

Your Relationship Status:

- Never Married Domestic Partnership Married Separated Divorced
 Widowed / How Many years? _____

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

If you have children, list gender & ages, and/or others present in your household:

Other relationship concerns: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

List any specific health problems you are currently experiencing:

2. Are you currently experiencing any chronic pain? No If yes, please describe

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

What types of exercise do you participate in _____

4. Are you currently experiencing any of the following symptoms? (please circle):

- | | | |
|-------------------|--------------------------------|---------------------------|
| Anxiety | Depression | Memory Difficulties |
| Panic | Loss of Interest | Anger |
| Loss of Appetite | Agitation | Helplessness |
| Dizziness | Too little sleep | Procrastination |
| Compulsions | Too much sleep | Confusion |
| Social Withdrawal | Hearing Voices | Easily Tearful |
| Obsessiveness | Loneliness | Visual Hallucinations |
| Sadness | Lack of Concentration | Thoughts that scare you |
| Grief | Difficulty initiation activity | Fatigue |
| Fear | Weight Gain | Excessive happiness |
| Nightmares | Weight Loss | Increased Disorganization |
| Impulsiveness | Outbursts | |

Rate (circle) your mood on a 0/10 scale: LOW < 1 2 3 4 5 6 7 8 9 10 >HIGH

5. Have you ever had a head injury, concussion (either a blow to the head, or sudden deceleration or violent shaking) in which you: (circle all that apply):

- a. Lost consciousness
- b. your consciousness was altered (your "bell was rung").
- c. you or others noticed that you seemed different afterwards
- d. your cognition or memory changed

When and how did this concussion or head injury occur? _____

6. Have you previously received any type of mental health services (psychotherapy, couples counseling, psychiatric services, etc.)? No Yes

If Yes, previous therapist/practitioner & dates:

Previous Psychiatric Hospitalizations? _____

Current prescription mental health medication? None Yes

If Yes Please list:

List any mental health medication in the past? None Yes

If Yes, Please list and provide dates:

Any Current or past natural or alternative meds, supplements or mental health treatments:

None If Yes, Please list and provide dates (circle those that you found most helpful):

7. If you drink alcohol, please note the type, amount and how many times per week?

_____ No, do not drink.

8. If you use recreational drugs, how often? Daily Weekly Monthly Never

What types _____

9. Have you had any inpatient or outpatient treatment for alcohol or drug use?

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following: If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Other Mental Diagnosis _____	yes / no	_____
Suicide Attempts	yes / no	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? No If Yes, what is your current employment situation:

Do you enjoy your work? Is there particular stress or problems in your current work?

2. Highest Grade completed in school or college? _____

3. Favorite interests, activities or experiences? _____

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

If Yes, describe your spirituality, faith or belief if you would like:

5. What do you like most about yourself or consider to be your best attributes?

6. Are there any concerns about self esteem or things about yourself you do not like?

7. Is there anything else you would like the Therapist to know? _____

I understand that completion of the above is for informational purposes and does not constitute a contract for services as further therapy concerns are generally addressed during the first appointment.

I agree to pay for sessions at the time of the appointment. If insurance is being utilized, I agree that it is my responsibility to understand my coverage, co-pays and deductibles, if any. The billing of insurance by the provider is a courtesy and I am ultimately responsible for payment of services provided.

Name Printed

Signature

Date

Please mail to;

Donald Ford, MA, LMFT, LPC
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