Intake Form

Please complete all of this form to the best of your ability. If you are the parent/legal guardian, please provide the information as it pertains to your child. All information is kept highly confidential. Please give this form to your counselor at the start of your appointment.

Client Name*: _____ Date of Birth: _____ Race: _____
Address: _____ Email: _____
_____ Highest Degree Completed: _____
_____ Home or Cell Phone: _____

Gender Identity: _____ Preferred Pronouns: _____

Sexual Orientation:_____

How did you hear about Sandra Hope Counseling? _____

Who else may come to the session with you? _____

*If the client is under 18, please provide the name, address and phone number of the parent(s)/legal guardian(s): _____

Current Employment

❑ Full-time ❑ Part-time ❑ Not Employed
Position: _____
Employer: _____
Address: _____
Annual Household Income: $_____

Marital Status

❑ Single ❑ Married ❑ Widowed ❑ Separated
❑ Divorced ❑ Remarried
Current Spouse/Date of Marriage: _____
Previous Spouse/Date of Marriage: _____
Previous Spouse/Date of Marriage: _____

Physical Health

Primary Physician: _____ Date/Report of Last Physical: _____

If you enter treatment with me, may I contact your medical doctor so that we might coordinate treatment? ❑ Yes ❑ No

Serious illnesses/injuries in the past 10 years: _____

Medications currently taking:_____

Recently, have you experienced a signficant change in your...

Weight? ❑ Yes ❑ No If yes, explain: _____
Sleep patterns? ❑ Yes ❑ No If yes, explain: _____

How often do you exercise per week? ❑ 0-1 Days ❑ 2-3 Days ❑ 4-5 Days ❑ More than 5 Days

Do you, or have you in the past...

Smoke? ❑ Yes, now ❑ Yes, in the past ❑ Never Comments: _____
Drink Alcohol? ❑ Yes, now ❑ Yes, in the past ❑ Never Comments: _____
Use illegal drugs? ❑ Yes, now ❑ Yes, in the past ❑ Never Comments: _____

Family History

	Name(s)	Age/Age at Death	Illness/Cause of Death	Quality of Relationship
Father:				
Mother:				
Step Parent(s):				
Sibling(s):				

Are you adopted? ❑ Yes ❑ No

Children's Names	Age	M/F	Live at Home?	From Previous Marraige?	Stepchild?	Quality of Relationship
_____	_____	M F	Y N	Y N	Y N	_____
_____	_____	M F	Y N	Y N	Y N	_____
_____	_____	M F	Y N	Y N	Y N	_____
_____	_____	M F	Y N	Y N	Y N	_____

Mental Health

Describe the chief concern that brings you to counseling. How long have you been deealing with this issue? _____

_____

Have you ever received psychological or psychiatric counseling services before?

❑ Yes, now ❑ Yes, in the past ❑ Never

When?	From Whom?	For What?	With What Result?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If necessary, may I contact these professionals? ❑ Yes ❑ No

Have you ever taken medications for psychiatric problems? ❑ No ❑ Yes: _____

Have you ever been abused physically/emotionally/sexually? ❑ No ❑ Yes: _____

_____

What are three things you like about yourself or see as your personal strengths? _____

_____

What are three things you would like to change about yourself? _____

_____

Spiritual Health

Write a brief statement about the role spirituality plays in your life._____

_____

_____

Your Commitment

1. I understand that because my counselor has reserved time exclusively for me, it is essential that I notify her at least 24 hours in advance if it is necessary to cancel my appointment. I understand that I may be charged my regular fee for 'no show' or late cancellations, with the exception of illness or emergencies.
2. I have read the introductory letter and have had an opportunity to ask any questions.
3. I have received and signed the financial contract.

Signature _____ Date _____