Balanced Life Counseling

finding balance in an unsteady world

Intake Form

Name ________________________________ Age_________ Date of Birth___/___/_____

Address____

____

Gender______________ Relationship Status____

May I contact you by email? _______ Postal mail? __________

E-mail Address____

Phone ______________________ Can I call you here? ________ Can I leave a message? ________

In case of emergency, please notify: ____

Phone: ________________________ Relationship to client: ______________________________

How did you learn about Balanced Life Counseling? (Check all that apply)

- ☐Psychologytoday.com
- ☐Health Insurance Directory
- ☐Balancedlifechicago.com
- ☐Friend/Relative
- ☐NAMI
- ☐Other: _____________________________

Briefly tell me about the issues/concerns that brought you to therapy.

Please check any current or past issues that still affect you.

- ☐Eating Disorder/Body Image
- ☐Academic Issues
- ☐Childhood Abuse (i.e. Physical, sexual, emotional)
- ☐Stress/Anxiety
- ☐Phobias (type: ______________)
- ☐Alcohol/Drug Use
- ☐Sexual Assault/Rape
  - ☐Recently (when: _________)
  - ☐In the past
- ☐Death of a loved one
  - ☐Recently (When: ________)
  - ☐In the past
- ☐Family Issues (i.e. Divorce, alcoholism, domestic violence)
- ☐Other: ____
- ☐Pregnancy Issues
- ☐Spiritual Concerns
- ☐Depression
- ☐Pornography
- ☐Sexual Problems
- ☐Relationship Concerns
  - ☐Family
  - ☐Friend
  - ☐Parent
  - ☐Significant other
  - ☐Roommate
  - ☐Coworker

Medical History

Current Medical Problems____

Current Medications (all, including herbal)____

Are you currently working with a psychiatrist? ____

If yes, what is your doctor's name? __________________________ Phone Number: _________________

What is the psychiatrist treating you for? ____

Have you been on any medications in the past for mental health issues? __________________________

(Please list) ____

Have you previously seen a therapist? ______ Who/Where? _____________________________________

How long ago? ____________ For what types of issues? ____

Have you ever been hospitalized for physical or mental health issues? (Briefly describe)

____

Have you had any previous suicide attempts? _________ (Briefly describe)

____

If you are currently experiencing any of the following symptoms, please rate them using the number key below.

Never 0 Seldom 1 Often 2 Always 3

___ Difficulty concentrating
___ Crying
___ Missing work/class
___ Feeling helpless
___ Feeling uptight/tense
___ Worrying
___ Feeling hopeless
___ Feeling afraid
___ Lying to others
___ Feeling out of control
___ Feelings of self-doubt
___ Injuring self
___ Nervousness around others

___ Memory loss or blackout
___ Difficulty sleeping
___ Stealing
___ Anger
___ Eating binges
___ Drinking heavily
___ Other drug use
___ Feelings of guilt
___ Withdrawing socially
___ Sexual preoccupation/obsessions
___ Suicidal thoughts
___ Loneliness
___ Physical symptoms (i.e. headaches, digestive problems)

Other: _____________________________

What do you hope to get out of our work together?