Jeannette M. Gilmore, M.A.

Intake Form

Name:_____ Date:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Referred by: _____

Age: _____ Date of Birth:_____

Marital Status:_____ Occupation:_____

Emergency Contact 1 (Name and Number)

_____

Emergency Contact 2 (Name and Number)

_____

Psychological History

Have you ever received counseling before? No Yes

If yes, when and for how long?

_____

What was the focus of treatment?

_____

What did you like most of treatment?

_____

What did you like least of treatment?

_____

Name of treating therapist(s) and telephone number(s):

_____

_____

Have you ever been hospitalized for mental or emotional problems? No Yes

If yes, when and for how long?

_____

Why were you hospitalized?

_____

Have you ever attempted suicide? No Yes

If yes, please list the approximate date, method, and outcome of attempt of each attempt:

_____

_____

_____

Are you currently having any suicidal thoughts? No Yes

Do you have any plans or intent to harm yourself? No Yes

If you answered yes to either of the 2 questions above, please bring this to your therapist's attention immediately.

Have you ever been diagnosed with a serious illness? No Yes

If yes, please describe:

_____

Are you currently taking any prescription medication? No Yes

If yes, please describe:

_____

Have you ever been prescribed psychiatric medication? No Yes

If yes, please describe:

_____

Are you currently experiencing any chronic pain? No Yes

If yes, please describe:

_____

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:

_____

How often do you drink alcohol? (please circle)

Never Daily Weekly Monthly Infrequently Socially

How often do you engage recreational drug use? (please circle)

Never Daily Weekly Monthly Infrequently Socially

Additional Information

Are you currently employed? No Yes

If yes, what is your current employment situation?

_____

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

_____

_____

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

If yes, describe your faith or belief:

_____

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

Treatment Goals

What significant life changes or stressful events have you experienced recently?

_____

_____

What issues/concerns are you hoping to work on in therapy? Please describe.

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?