

Individual Intake Form

Please complete this form and bring it with you to your first appointment. The information is to help your counselor understand you and your concerns. If you have any questions or concerns regarding this form, you will have an opportunity to discuss this with your counselor during your session. Your counselor will review your completed form with you in your first few session. All information is confidential unless released by written consent except as otherwise required by law.

Today's Date: ___/___/___

Personal Information

Name: _____ Preferred Name: _____

Date of Birth: ___/___/___ Age: _____ Gender: _____ Pronoun: _____

Highest Level of Education Completed: _____

Occupation: _____ Employer: _____

Contact Information

Home Address: _____
City _____ State _____ Zip Code _____

Mobile Phone: (____) _____ - _____ May we leave a message? Yes ___ No ___

Work Phone: (____) _____ - _____ May we leave a message? Yes ___ No ___

Home Phone: (____) _____ - _____ May we leave a message? Yes ___ No ___

Email: _____

Emergency Contact

Name: _____ Relationship to you: _____

Phone 1: (____) _____ - _____ Phone 2: (____) _____ - _____

Your Marital/Relationship Status

Single Married Separated Divorced Partnered
 Domestic Partnership Widowed Other (explain) _____

Your Children

Name: _____ Age: ___ Name: _____ Age: ___

Name: _____ Age: ___ Name: _____ Age: ___

Other People Living in Your Household

Name: _____

Relationship to you: _____

Name: _____

Relationship to you: _____

Risk Assessment

In the last two weeks, have you felt at risk of harming yourself? Y___ N___ Harming others? Y___ N___

If yes, please explain: _____

In the past, have you felt at risk of harming yourself? Y___ N___ Harming others? Y___ N___

If yes, please explain: _____

Do you experience violence or abuse at home, at work, or in other situations? Y___ N___

If yes, please explain: _____

Referral Information

How did you hear of our clinic? _____

Biological Factors

Have you ever been diagnosed with a mental health disorder? Y___ N___

If yes, when were you diagnosed, and what was the diagnosis? _____

Are you currently under a physician's care for any reason? Y___ N___

If yes, please explain: _____

Please list any current medications, dosage amounts, and reason for prescription:

Prescriber Name, Clinic Name and Phone Number:

Do you currently use drugs or substances other than the medications listed above?

(e.g. over-the-counter medicine, recreational drugs, alcohol, tobacco, etc.) Y___ N___

If so, please explain what and how often:

All information is confidential unless released by written consent except as otherwise required by law.

Your Journey

There is something important about your seeking counseling services at this moment in your life. Please explain why you are seeking counseling now: _____

Have you been in therapy or counseling before? Y___ N___

If so, please explain briefly why you sought out counseling in the past, and how it did or did not help you:

What do you hope to gain from your counseling at M.E.T.A. Counseling Clinic?
