Mindful Experiential Therapy Approaches, LLC
M.E.T.A. Counseling Clinic
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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?

_____

_____

_____

_____