

Hope Heals Counseling, LLC

Intake Form

This Document is Confidential

Client Information

Today's Date: ____/____/____ Referred By (How did you hear about HHC): _____

Name: _____

Address _____ City _____ St _____ Zip _____

Phone: _____ E-Mail: _____

Preferred Method of Communication: E-mail, phone or text? (Circle one)

Date of Birth: ____/____/____ Gender: M / F Ethnicity: _____

Highest Educational Level: _____

Occupation: _____

Spiritual Background: _____

Family of Origin

Fathers name and age: _____ Mother's name and age: _____

Are they: Married / Divorced / Remarried / Etc. (Please explain): _____

If remarried: Step Father/Mother's Name & Age: _____

Sibling: Names and ages (Please include step, adopted, half and/or deceased): _____

Marriage & Children

Marital Status (Circle all that apply): Single / In Relationship / Engaged / Married / Separated / Divorced / Widowed

Spouse's Name & Age: _____ Occupation: _____

Do you have children? Y / N

If so, Please list them below and indicate if you have any adopted, step and/or deceased children and their age:

_____	_____
_____	_____
_____	_____

Medical & Personal

Have you Had Counseling Before? Y / N If yes, Outcome/Diagnosis: _____

If you are on medications, what kind(s)? _____

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Do you have or suspect any addiction(s)? (Alcohol, Drugs, Sex, Eating Disorders, Pornography, etc.) Y / N / Uncertain

If yes or uncertain, share more: _____

Have you had any previous trauma? (Physical, emotional, sexual abuse, abortion, etc?) Y / N / Uncertain

If yes or uncertain, share more: _____

Have you ever been arrested? Y / N

If yes, share more: _____

Do you have a family history of mental disorders? Y / N / Uncertain

If yes or uncertain, share more: _____

Have you ever been hospitalized for mental or physical reasons? Y / N

If yes, share more: _____

Do you feel safe in your current living environment? Y / N / Uncertain

If no or uncertain, share more: _____

Do you have any suicidal thoughts or plans? Y / N

If yes, share more: _____

What is your current level of distress? (10 = extreme)

1 2 3 4 5 6 7 8 9 10

I regularly feel (circle all the apply): Depressed, Angry, Anxious, Fearful, Emotional, Violated, Sorrow, Guilt, Lazy, Boredom, Rejected, Stress, Lonely, Regret, Helpless, Irritated.

Please finish the following sentences

I feel understood when: _____

My Childhood was: _____

When I am angry I: _____

My Strengths are: _____

My Weaknesses are: _____

Basic Information

What concern has caused you to come for counseling? _____

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What has been done about your concerns? _____

Has this concern occurred before *(if so, please explain)*? _____

What specifically do you expect your counselor to do to help with your concerns?

By my signature, I affirm that I have read and answered these statements honestly and to the best of my ability.

Client's Printed Name: _____

Client's Signature: _____

Date: ____/____/____