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: ____

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

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

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What concern has caused you to come for counseling? ____

____

____

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: _____/______/______