CONFIDENTIAL CLIENT INTAKE

Emily Sinclair Counseling, PLLC

Please fill out this form and bring it to your first session.
Please note: Information you provide here is protected as confidential information.

Name: _____

Mailing Address: _____

Phone Numbers: Home: _____ May I call you here? Yes No

Work: _____ May I call you here? Yes No

Cell: _____ May I call you here? Yes No

E-mail: _____ May I email you? Yes No

**Please note: email correspondence is not considered to be a confidential medium of communication.*

Birth Date: _____ /_____ /_____ Age: _____ Gender: Male Female

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Please list any children/age: _____

Name of Parent or Guardian (if under 18): _____

Emergency Contact Name: _____ Number: _____

How did you hear about me? _____

Referred by (if any): _____

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation/Divorce	Relationships
Finances	Drug/Alcohol Use	Career Choices	Anger
Self-Control	Unhappiness	Insomnia	Religious Matters
Work/Stress	Health Problems	Cutting/Self-Mutilation	Thought Patterns

Other: _____

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GENERAL HEALTH, MENTAL HEALTH, & HISTORY OF CARE

Name of Personal Physician & Phone Number: _____

Circle a rating for your current physical health: Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

Are you currently taking *any* prescribed medications? Y / N - If yes, please explain/list below.

List any psychiatric/mental health medications you have taken, or are taking.

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name and date of the therapy and briefly explain the circumstances:

Have you ever been hospitalized for a mental health condition? Y / N
If yes, please give the date and briefly explain the nature of the problem that required attention:

Do you or have you practiced in cutting or other form of self-harm? Y / N
If yes, please describe and provide some details:

Have you ever attempted or considered suicide, wished you were dead, or wanted to go to sleep and not wake up? Y / N
If yes, how recently, and please provide some details:

Thank you for your time and effort to fill out this form as completely as possible.

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Have you ever been in a drug or alcohol treatment program? Y / N
If yes, please give the facility, length of time in treatment and outcome:

Do you currently drink alcohol? Y / N
How much? How often? What type?

Do you currently use recreational drugs? Y / N
How often? What substances?

Do you feel you have a problem with either alcohol or drugs? Y / N

Recent weight gain or loss: Y / N
If yes, please describe, and name any difficulties you experience with your appetite or eating patterns:

Circle a rating for your current sleeping habits: Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____
Please list types of exercise in which you participate:

Are you currently experiencing overwhelming sadness, grief, or depression? Y / N
If yes, for approximately how long?

Are you currently experiencing anxiety, phobias, or having panic attacks? Y / N
If yes, please describe, and for how long?

Are you currently experiencing any chronic pain? Y / N
If yes, please describe:

Are you currently in a romantic relationship? Y / N If yes, for how long? _____

If yes, on a scale of 1-10, please rate your relationship: _____

Thank you for your time and effort to fill out this form as completely as possible.

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FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle:		List Family Member:
Alcohol/Substance Abuse	Y / N	
Anxiety	Y / N	
Depression	Y / N	
Domestic Violence	Y / N	
Eating Disorders	Y / N	
Obesity	Y / N	
Obsessive Compulsive Behavior	Y / N	
Schizophrenia	Y / N	
Suicide Attempts	Y / N	

ADDITIONAL RELEVANT INFORMATION

Are you currently employed? Y / N
If yes, what is your current employment situation? If no, please describe your circumstance.

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

Do you consider yourself to be spiritual or religious? Y / N
If yes, describe your faith or belief:

What would a friend or family member consider to be some of your strengths or best qualities?

Do you agree? If not, please explain:

What would a friend or family member consider to be some of your weaknesses or rough edges?

Do you agree? If not, please explain:

Thank you for your time and effort to fill out this form as completely as possible.

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STATEMENT OF NEED

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

Please provide a brief description of your reasons for seeking counseling at this time.

How have these concerns evolved over time?

What are your goals for our counseling work?

Is there anything else you think I should know about prior to our beginning your treatment?

Thank you for your time and effort to fill out this form as completely as possible.