**Patient Information Intake Form**

What brings you to counseling at this time? Is there something specific, such as a particular event? Please be as detailed as you can.

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What are your goals for counseling?

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Have you seen a mental health professional before?

If Yes, please expound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Specify all medications and supplements you are presently taking and for what reason.

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If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

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Who is your primary care physician? Please include type of MD, name and phone number.

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Do you drink alcohol?

If Yes, please state how much and how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you use recreational drugs?

If Yes, please state how much and how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have suicidal thoughts?

If Yes, please state how often these thoughts occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever attempted suicide?

If Yes, please state when the attempt occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have thoughts or urges to harm others?

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized for a psychiatric issue?

If Yes, please state where and when hospitalization occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there a history of mental illness in your family?

If Yes, please expound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you are in a relationship, please describe the nature of the relationship and months or years together.

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Describe your current living situation. Do you live alone, with others. With family, etc...

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What is your level of education? Highest grade/degree and type of degree.

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What is your current occupation? What do you do? How long have you been doing it?

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Please circle any of the following you have experienced in the past six months:

 Increased appetite

 Decreased appetite

 Trouble concentrating

 Difficulty sleeping

 Excessive sleep

 Low motivation

 Isolation from others

 Fatigue/low energy

 Low self-esteem

 Depressed mood

 Tearful or crying spells

 Anxiety

 Fear

 Hopelessness

 Panic

 Other

Please circle any of the following that apply to your medical history:

 Headache

 High blood pressure

 Gastritis or esophagitis

 Hormone-related problems

 Head injury

 Angina or chest pain

 Irritable bowel

 Chronic pain

 Loss of consciousness

 Heart attack

 Bone or joint problems

 Seizures

 Kidney-related issues

 Chronic fatigue

 Dizziness

 Faintness

 Heart valve problems

 Urinary tract problems

 Fibromyalgia

 Numbness & tingling

 Shortness of breath

 Diabetes

 Hepatitis

 Asthma

 Arthritis

 Thyroid issues

 HIV/AIDS

 Cancer

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What else would you like me to know?

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Thank you for sharing and completing this form.