**Intake Form**

Calm Counseling, LLC

Date: Name: .

SSN: Gender: Birthdate: Age: .

Race/Ethnicity (optional): Religious Affiliation (optional): .

Local Address: .

Employment location: .

Insurance Provider & ID# (for OON invoices): .

Primary phone #: Primary Email Address: .

May we contact you and leave a message regarding therapy? By phone: yes / no By email: yes / no

Have you been to counseling before? yes / no If so, when? . .

Has anyone referred you to come here? .

Briefly tell us about the concerns that have brought you here: .

 .

 .

 .

Please check any current AND/OR past issues that still affect you:

* Eating disorders
* Academic issues
* Childhood abuse (circle all that apply: physical, sexual, emotional)
* Stress/anxiety
* Phobias (type: )
* Alcohol/other drug use (if so, what: )
* Sexual assault/rape (if so, when: )
* Death of someone close (when: )
* Addictions (type: )
* Family issues (circle if apply: Divorce, Alcohol, Domestic Violence)
* Pregnancy issues
* Spiritual concerns
* Depression
* Pornography
* Sexual identity issues
* Relationship concerns (circle all that apply): Family, Friend, Parent, Significant Other, Child
* Financial issues
* Suicidal thoughts
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

Current health problems: .

List current medications: .

 .

Have you been on medications in the past for mental health issues? Yes / No If so, please list below:

 .

Have you seen a therapist in the past or been hospitalized? Yes / No

If so, briefly describe: .

Have you had any previous suicide attempts? Yes / No Describe: .

Does anyone in your family have a history of mental/physical health issues? Who? What type? .

 .

*If you currently experience the following symptoms, please rate them using the following scale below:*

0 = never 1 = seldom 2 = often 3 = always

\_\_\_difficulty concentrating \_\_\_anger

\_\_\_crying \_\_\_negative thoughts about body

\_\_\_feeling helpless \_\_\_consumed with changing appearance

\_\_\_feeling uptight \_\_\_distressed when exercise routine broken

\_\_\_worrying \_\_\_eating binges

\_\_\_feeling hopeless \_\_\_restricting food or not eating

\_\_\_feeling afraid \_\_\_purging/throwing up

\_\_\_lying to others \_\_\_drinking heavily

\_\_\_feeling out of control \_\_\_other drug use

\_\_\_feeling self-doubt \_\_\_guilt feelings

\_\_\_injuring self (How:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_withdrawing socially

\_\_\_nervous around others \_\_\_sexual preoccupation

\_\_\_stealing \_\_\_physical symptoms (headaches, digest)

\_\_\_memory loss or blackout List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_difficulty sleeping \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_suicidal thoughts \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in a counseling group? Yes / No , Topic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please scale the following questions:*

1 = not at all true 2 = somewhat true 3 = mostly true 4 = true to a great extent

\_\_\_\_My current concerns affect my success in my family and/or work place.

\_\_\_\_My current concerns affect my ability to interact and connect with my family and/or friends.

\_\_\_\_I am optimistic that I will be able to make some positive changes as a result of counseling.