

## Intake Form

Date: \_\_\_\_\_

**Client Name:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Race: \_\_\_\_\_ Permission to leave VM  send text (appointments)  send email

Sexual Identity: Heterosexual  Gay  Lesbian  Bisexual  Unsure  Other: \_\_\_\_\_

Preferred Pronouns: \_\_\_\_\_ Status: Single  Married/partnership  Separated

Divorced  # \_\_\_\_\_ Widowed  Never Married

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Any Disability? Yes  No  (if "Yes," please explain) \_\_\_\_\_

\_\_\_\_\_

Suicidal Ideation/Planning? Yes  No  (if "Yes," please explain)

\_\_\_\_\_

Psychiatric Diagnosis? Yes  No  (if "Yes," please explain)

\_\_\_\_\_

Medical Conditions? Yes  No  (if "Yes," please list them)

\_\_\_\_\_

Any Medications? Yes  No  (if "Yes," please list them)

\_\_\_\_\_

**Spouse/Partner** (couple therapy): \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Race: \_\_\_\_\_ Permission to leave VM  send text (appointments)  send email

Sexual Identity: Heterosexual  Gay  Lesbian  Bisexual  Unsure  Other: \_\_\_\_\_

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Suicidal Ideation/Planning? Yes  No  (if "Yes," please explain)

Psychiatric Diagnosis? Yes  No  (if "Yes," please explain)

Medical Conditions? Yes  No  (if "Yes," please list them)

Any Medications? Yes  No  (if "Yes," please list them)

**Children:** Yes  No  (if "Yes," list children's information below)

Name	Date of Birth	Gender	Custody/Adult

**List the Primary Care Physicians for Individual Client, Partner (if applicable), Children**

Name	Address	Phone

Reason you're seeking counseling at this time:

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Any symptoms of psychological distress:

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Have you been in counseling before? Yes  No  (if "Yes," was it helpful?) \_\_\_\_\_

Who did you grow up with? \_\_\_\_\_ Siblings # \_\_\_\_\_ Closest to: \_\_\_\_\_

Childhood adversities? Yes  No  (if "Yes," please explain)

\_\_\_\_\_

Coping mechanisms/tendencies:

\_\_\_\_\_

Social support:

\_\_\_\_\_

Spirituality? Yes  No  (if "Yes," please explain)

\_\_\_\_\_

Anything else you want the counselor to know:

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_