American Health Network
Fredericktown
Counseling Intake

Basic Information

Today's date:_____ Date of birth:_____
Name (first, middle, last)_____
Address:_____
City:_____ State:_____ Zip code:_____
Home phone:_____ Cell Phone:_____

Briefly Answer the Following Questions

What is the main problem as you see it or the reason you are here?_____

What are your goals for counseling?_____

Any additional information or concerns?_____

Health, Wellness, Interests

Physician:_____ Phone:_____
List all important present or past illnesses, injuries, or handicaps:_____

Do you have problems sleeping? ◯ Yes ◯ No
Have you ever felt hopeless to the point of wanting to hurt yourself? ◯ Yes ◯ No
If yes, please explain:_____

Recent weight changes: ◯ Lost ◯ Gain ◯ N/A
Do you drink alcoholic beverages? ◯ Yes ◯ No
If yes, amount and how often?_____
Are you currently using or have you previously used drugs for non-medical purpose?_____
If yes, please explain:_____

Have you ever had a severe emotional crisis? ◯ Yes ◯ No
If yes, please explain:_____

Have you participated in therapy or counseling? ◯ Yes ◯ No
If yes, please explain:_____

Have you been psychiatrically hospitalized? ◯ Yes ◯ No
Date(s):_____ Number of days:_____
Hospital(s):_____
Chief reason for hospitalization:_____

What is your current level of physical activity? ◯ Vigorous ◯ Moderate ◯ Inactive
What physical activities do you enjoy?_____

What hobbies, special interests, and/or recreational activities do you enjoy? _____

What community activities, including volunteer work, are you involved in?_____

Are there any culture or beliefs that are important to you, including spiritual or religious beliefs? _____

Relationship Information

Relationship Status: ◯ Single ◯ Dating ◯ Engaged ◯ Married
◯ Divorced ◯ Widowed ◯ Separated ◯ Remarried

Spouse/Partner's name:_____ Date of birth:_____
If dating, how long have you been in a relationship with your partner?_____
If married, how long have you been married or with your partner?_____
Have you ever been separated? ◯ Yes ◯ No
Is your spouse/partner willing to come to counseling? ◯ Yes ◯ No ◯ Uncertain

Information about Children

Name	Age	Sex	Marital Status
		◯ M ◯ F	◯ S ◯ M ◯ D
		◯ M ◯ F	◯ S ◯ M ◯ D
		◯ M ◯ F	◯ S ◯ M ◯ D
		◯ M ◯ F	◯ S ◯ M ◯ D
		◯ M ◯ F	◯ S ◯ M ◯ D

Education and Work

Grade in School: K 1 2 3 4 5 6 7 8 9 10 11 12
School (if applicable):_____

College: 1 2 3 4 5 6+
Other training/education:_____
_____

Occupation (if applicable):_____
Employer (if applicable):_____
Have you or are you currently serving in the Military? ◯ Yes ◯ No
If yes, please explain:_____
_____

Family History

Name	Relationship (i.e. father, mother, sibling)	Age

Rate your parents' marriage/relationship: ◯ Very Happy ◯ Happy ◯ Average ◯ Unhappy
Rate your childhood life: ◯ Very Happy ◯ Happy ◯ Average ◯ Unhappy

Additional information:_____
_____

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart kept at American Health Network, may not be released to anyone without my written consent, with these exceptions:
***If the law mandates disclosure.**
***If you have placed yourself or someone else in clear and imminent danger.**
***For the purposes of therapist supervision & consultation, within the ethical guidelines of the American Counseling Association.**

Print Name (Person completing questionnaire):_____

Signature_____ Date:_____