Intake Form

Wellness Counseling & Consulting Services
20512 SW Roy Rogers Rd., Suite 150, Sherwood, OR 97140
(503) 833-2566

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Social Security Number: _____

Gender: □ Male □ Female □ Nonbinary Pronouns: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Engaged □ Married □ Separated

□ Divorced □ Widowed

Please list any children/names/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Contact Phone: ( ) _____ Is this a mobile phone? □ Yes □ No

May we leave a message/text? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner, date: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list (including why it was prescribed and dosage):

_____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. How often do you drink alcohol? □ Daily □ Weekly □ Infrequently □ Never

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

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	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation (employer, title, hours worked per week):

_____

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

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

6. Are you planning on using health insurance to help pay for your counseling? □ No □ Yes

If Yes, please complete the following information:

Insurance Provider: _____ Member ID: _____

Group ID: _____ Name as listed on card: _____

Are you the primary member? □ Yes □ No If not, who is? _____

Primary's DOB: _____ Primary's Phone: _____

Primary's Address (if different from you): _____