Sarah Larsen Counseling

Intake Form

Client Information

NAME	GENDER (M/F)
ADDRESS	
CITY	ZIP
DATE OF BIRTH	
CELL #	EMAIL

Relationship Status

Single Engaged Married Divorced Separated Widow(er) Living Together Other

If married, how long? _____

Emergency Contact

Name: Relationship to you:

Cell Phone:

Please state the nature of your problem and what you would like to accomplish through counseling

_____

_____

_____

How serious does this problem feel to you?

1 2 3 4 5

(mildly upsetting) (extremely serious)

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Previous Treatment

Have you ever seen a counselor/therapist/psychologist? If yes, please provide the name, problem and duration of counseling:

Reason for terminating previous counseling:

Was counseling helpful/successful for you?

Have you previously seen a psychiatrist?

If yes, name of psychiatrist:

Date of last appointment:

Diagnosis, if any:

Any Medications prescribed:

Medical Information

Primary Medical Doctor: Phone #:

Date of Last Physical:

List all Prescription Medications:

Medical History

Have you ever been hospitalized? If yes, name date(s).

Have you ever been in a serious accident? If yes, name date(s).

Have you ever had a major illness? If yes, name date(s).

Do you have a chronic illness (ie. allergies, asthma, diabetes, auto-immune disorders)?

Have you ever had a head injury, lost consciousness? If yes, name date(s).

How much and how often do you consume alcohol?

Do you use other substances? What type? How much and how often?

Circle if you experience any of the following:

Mood Swings	Excessive anxiety/worry	Angry feelings
Phobias/Fears	Low energy	Panic attacks
Suicidal thoughts	Loneliness/social withdrawal	Guilt feelings
Excessive Sleep/Fatigue	Difficulty making decisions	Difficulty making friends
Insomnia	Angry outbursts	Loss of interest in sex
Loss of Appetite	Changes in weight	Unusual/irrational thoughts
Binge eating/Overeating	Loss of interest in usual activities	Delusions/Hallucinations
Restrictive eating	Lack of motivation	Feeling numb/cut off from emotions
Headaches	Trouble with concentration	Flashback
Nightmares	Compulsions with specific activities	Intrusive Thoughts

Do you sleep well? How many hours per night?

Do you exercise regularly?

Have you ever attempted suicide?

Has anyone in your family ever attempted suicide?

What was the most difficult time in your development? Circle and briefly explain why:

Preschool Grade School Jr. High High School College Now

Occupation/School

Highest education level?: _____

Are you employed?: _____ Employer's Name: _____

Are you currently attending school? _____ School's Name: _____

Name of Major: _____

Family History

Did you grow up with both parents in the home? _____

If no, how old were you when they divorced? _____

Are your parents still married? _____

Briefly describe your relationship with your mother? Your father?

_____

_____

Briefly describe your siblings and your relationship with them?

Describe your children (include names and ages).

Do you have any specific parenting challenges?

Circle any of the following that you experienced in childhood and adolescence:

Deaths Divorce Accidents Health struggles Frequent move
Neglect Attention problems Anxiety Weight/Body image

Is there any history of mental health issues ie. depression, anxiety, suicide, substance abuse, child abuse or domestic violence in your family?

Tell me about your faith, spirituality, church affiliation/experiences.

Strengths

What do you do for fun? (sports/hobbies/other)?

Is there anything else you would like me to know?