Elizabeth Davis LMFT, BCBA

Pre-Counseling Intake Information Form

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.

Date:_____ Referred by:_____

Your Name:_____ Birthdate:_____Age:_____

Address:_____ SS #:_____

_____Zip_____ Hm Phone:_____Wk Phone:_____

Email: _____

*Please note: Email and Text correspondence is not considered to be confidential mediums of communication.

Insurance Information

Name of Insured: _____ SS #:_____Date of Birth:_____

Insurance Name:_____ Group #:_____

Authorization # :_____ Dr. Name & Phone # :_____

Employment Information

Employer:_____ Occupation/Title:_____

How Long? _____ Have you ever been unable to work? _____Y _____ N

Reason: _____ Have you served in the military? _____ Y _____ N

Number of years: _____ Location/Duty: _____

Current Situation

Why are you seeking counseling? _____

_____

Why did you decide to come in at this time? Please be specific about anything that has changed *recently.* _____

_____

What would you like to accomplish out of your time in counseling? _____

_____

Have you been in counseling before? ____Y ____ N If so, please list the therapist and circle whether you had a positive (+) or negative (-) experience:

Therapist Name: _____ Dates of Service: _____ + -

Emergency Contact Information

Name: _____Relationship: _____

Phone number: _____

Current Family Status

I am: ____ Single ____ Married ____ Sig. Other ____ Separated ____ Divorced ____ Widowed

Spouse/Partner Name: _____ Their Occupation: _____

Do you have children? _____ Y _____ N Does your spouse/partner have children? _____ Y _____ N

Child's Name: _____ Birthdate & Age: _____
Child's Name: _____ Birthdate & Age: _____
Child's Name: _____ Birthdate & Age: _____
Child's Name: _____ Birthdate & Age: _____

If you are divorced, please describe your custody and/or visitation arrangement with your children: _____
_____

Please list anyone else living in your home: _____

Have you been married previously? If yes, when? _____

If you are currently married or in a relationship, please rate your level of contentment/happiness/satisfaction in the relationship on a scale of 1 to 10. (1 = extremely happy and 10 = extremely unhappy)_____
Please briefly explain the rating you gave. _____
_____

On a scale of 1 to 10, describe your level of commitment to your relationship. (1= very committed and 10 = not feeling at all committed) Please briefly explain the rating you gave. _____
_____

Do you consider yourself to be spiritual or religious? If so, please describe your faith or belief.
_____

What do you consider to be some of your <u>strengths</u>? _____
_____

What do you consider to be some of your <u>weaknesses</u>? _____
_____

Childhood and Family History

Were your parents together throughout your childhood? _____ Y _____ N If not, why? _____

Number of times you moved as a child: _____ Mostly lived in: ____City ____Town ____Suburbs ____Country

Please check any special circumstances in your childhood family:

___ disabled child ___ disabled parent ___ serious/chronic illness ___ death of parent ___ hospitalizations

___ alcoholism ___ drug abuse ___ mental illness ___ parents fighting ___ parent unemployed

___ foster care ___ legal problems ___ sibling conflicts ___ emotional abuse ___ physical abuse

___ sexual abuse ___ suicide attempts

Please list any other issues or events you consider significant and your age when the event(s) occurred: _____
_____

What were you like as a child? _____ average _____ tried to be perfect _____ shy _____ outgoing _____isolated
_____ felt you didn't belong _____ lonely _____ avoided home _____ used drugs ____ used alcohol
_____ had learning problems _____ legal problems _____ had too much responsibility
Other:_____

Please briefly describe your childhood and your relationships with your parents and siblings: _____
_____

Please check the highest level of education you have received: ____ grade 1-8 ____ Some High School (no diploma)
____ High school Diploma/GED ____ Some College (no degree) ____Technical/Trade School Graduate
____ Associate Degree ____ Bachelor Degree ____ Master Degree ____ Professional Graduate Degree
____ Doctoral Degree (PhD, EdD, etc.)

_____

Hang in there! You're half the way done... 

Medical Information

Do you have any medical conditions? _____ Y _____ N If so, please list it and the age it began:
Condition: _____ Age: _____
Condition: _____ Age: _____

Are you currently taking any medications? _____ Y _____ N If so, please list: _____
_____
_____
Have you ever been prescribed psychiatric medication? ____Y ____N Doctor's Name & Phone: _____
Please list and provide dates: _____
_____

Do you use, or have you ever used, any non-prescription substances? ____ Y ____ N
If so, please list: Include **caffeine, alcohol, tobacco, herbal preparations, marijuana**, etc.
Substance: _____ Current Use: _____ Past Use: _____
Substance: _____ Current Use: _____ Past Use: _____
Substance: _____ Current Use: _____ Past Use: _____
Substance: _____ Current Use: _____ Past Use: _____
Does anyone else in you home use substances? _____ Y _____ N Please list: _____
_____

Have you ever been in treatment for drug or alcohol related issues? _____ Y _____ N
If so, please list the treatment facility/program and the treatment dates. Please include AA or NA groups: _____
_____

Have you ever been hospitalized because of a mental health disorder: _____Y _____N If yes please briefly describe: __
_____

Legal History

Have you ever been ordered by the court to participate in therapy? _____Y _____N If yes please list the date and briefly describe the circumstances. _____
_____

Are you currently involved in any kind of litigation or legal dispute? _____ Y _____ N If yes, please explain _____
_____

One Last Page to Go…

PLEASE COMPLETE THE SYMPTOM CHECK LIST

Symptom Checklist ***Please consider how you have been feeling for the last 2-3 months.***

Please check all that apply, ***even*** *if they are not related to the problem you are seeking counseling for.*
This information helps me make a more comprehensive plan for your treatment.

	Trouble going to sleep		Vomiting
	Restless sleep		Hot or cold spells
	Wake early and can't go back to sleep		Numbness or tingling in extremities
	Sleep too much		Allergies
	Feel guilty		High blood pressure
	Depressed, especially in the morning		Menstrual irregularity or distress; include PMS, Menopause
	Thoughts of suicide		Asthma
	Have made suicide attempt(s)		Hives
	Fatigue, loss of energy		Irritable bowels, constipation or diarrhea
	Poor concentration		Tics, uncontrolled muscle twitches
	Memory loss, problems		Smoking
	Decreased sex drive		Crave sugar sweet foods
	Restless, unable to relax		Eating disturbance (over focus on food, dieting, weight)
	Loss of interest or pleasure in usual activities		Starving, binging or purging
	Reduced appetite		Frequent flues or colds
	Feel worthless		Increased or frequent minor accidents
	Irritable		Sinus problems
	Recent or sudden weight change (loss or gain)		Grind teeth, jaw tension, or jaw pain
	Feel sad or depressed		Joint pain
	Withdrawn from others		Metabolic dysfunction (thyroid, diabetes, hypoglycemia)
			Heart disease
	Heart palpitations, rapid heartbeat		Uncontrollable thoughts
	Light-headed, dizzy		Uncontrollable habits, movements, behaviors
	Unusual sweating		Other:
	Trembling		
	Sense of dread		Argue with others
	Muscle tension		Feel critical of others
	Chest pains		Believe that others dislike you
	Frequent urination		Feel shy or uneasy around others
	Panic attacks		Want to be alone often
	Short of breath		Difficult to communicate what you think or feel
	Cold, clammy hands		Feel bored with others
	Disturbing dreams, nightmares		Feel inadequate, less than others
	Afraid to lose control		Believe that others do not understand you
	Avoid certain situations		Feel lonely, even around other people
	Nausea, upset stomach		Feel that others are inferior to you
	Nightmares, intense dreams		
			Ulcers
	List Others:		Headache
			Itching
			Low back pain