DEMOGRAPHIC INFORMATION

NAME: ______________________ AGE: ________ TODAY'S DATE: ____________

TEMPORARY ADDRESS: ______________________ PHONE (CELL): ____________

______________________ PHONE (HOME): ____________

PERMANENT ADDRESS: ______________________ PHONE (WORK): ____________

____

DATE OF BIRTH: ______________ EMAIL ADDRESS: ______________________

CONTACT PERSON IN CASE OF EMERGENCY: ______________________

NATURE OF RELATIONSHIP:__________ PHONE #1: __________ PHONE #2: __________

EMPLOYER/SCHOOL: ______________ YOUR POSITION/GRADE: ______________

PRIMARY CARE PHYSICIAN: ______________________ PHONE: ______________

WHO REFERRED YOU HERE? ______________MAY WE THANK THEM FOR THE REFERRAL? ☐ ***YES*** ☐ ***NO***

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME: ______________________ INSURANCE ID #: ______________

INSURED'S NAME: ______________________ INSURED'S DATE OF BIRTH: ______________

CO-PAY AMOUNT: __________ SEND CLAIMS TO: ______________________

SECONDARY INSURANCE PLAN NAME: ______________________ INSURANCE ID #: ______________

SECONDARY INSURED'S NAME: ______________________ INSURED'S DATE OF BIRTH: ______________

CO-PAY AMOUNT: __________ SEND CLAIMS TO: ______________________

FOR INTERNAL PURPOSES ONLY

DIAGNOSTIC CODE: ______________________ INS ☐ PP ☐ ADJ ☐

RELATIONSHIPS

RELATIONSHIP STATUS

- ☐ Never Married
- ☐ Married / ☐ Partnered *living together (How Long?) ___________
- ☐ In a Relationship/Exclusively Dating *not living together (How Long?)__________
- ☐ Separated (How Long?) ____________
- ☐ Divorced (How Long?) ____________
- ☐ Widowed (How Long?) ____________
- ☐ Previous Marriages (How Many?) ____

HOME

With whom do you live?	Age	Relationship to you	Quality of relationship

COLLEGE/DORM

With whom do you live?	Age	Relationship to you	Quality of relationship

Is there violence in your household or with your significant other? ☐ Yes ☐ No

Have you ever experienced any of the following types of abuse:

- ☐ Physical
- ☐ Emotional
- ☐ Sexual
- ☐ Verbal

Names of relatives and/or significant friends you turn to for emotional support: ____

____

____

Please check all that apply about your relationships:

- ☐ I keep mostly to myself
- ☐ I prefer to be with people
- ☐ I have no close friends
- ☐ I have only one close friend
- ☐ I have a few close friends
- ☐ I have many close friends
- ☐ I have a hard time feeling close to others
- ☐ I make friends easily
- ☐ I have a difficult time trusting people
- ☐ I trust others easily

Do you participate in extra-curricular activities outside of work or school? ☐ Yes ☐ No

If yes, please describe: ____

Do you identify with any religion? ☐ Yes ☐ No If so, which? ____

If so, do you have relationships within a faith community? ☐ Yes ☐ No

GENDER & SEXUALITY

DO YOU CONSIDER YOURSELF: ☐ *MALE* ☐ *FEMALE*

☐ *TRANSGENDER-MALE* ☐ *TRANSGENDER-FEMALE*

☐ *GENDER NON-BINARY* ☐ *BI-GENDERED*

☐ *OTHER* ______________________________

DO YOU CONSIDER YOURSELF: ☐ *STRAIGHT* ☐ *LESBIAN* ☐ *GAY*

☐ *BISEXUAL* ☐ *QUEER* ☐ *BI-CURIOUS*

☐ *ASEXUAL* ☐ *OTHER* ______________________________

DO YOU CURRENTLY HAVE: ☐ *1 PARTNER* ☐ *MULTIPLE PARTNERS* ☐ *NO PARTNERS*

DO YOU PRACTICS SAFE SEX? ☐ *SOMETIMES* ☐ *ALWAYS* ☐ *NEVER* ☐ *N/A*

HEALTH & WELLNESS

CURRENT HEALTH CONCERNS: ______________________________

____

CURRENT MEDICATIONS: ______________________________

____

HOSPITALIZATIONS &/OR SURGERIES: ______________________________

____

PREVIOUS COUNSELING, EAP, EATING DISORDER, &/OR CHEMICAL DEPENDENCY TREATMENT:

Facility/Counselor Name	*Dates*	*Reason for Treatment*	*Was it Helpful?*

HAVE YOU EVER TAKEN LEAVE FROM SCHOOL OR WORK FOR MENTAL HEALTH, EATING DISORDER, OR CHEMICAL DEPENDANCY? ☐ ***YES*** ☐ ***NO***

DO YOU HAVE A PERSONAL OR FAMILY HISTORY OF ANY OF THE FOLLOWING? (Please check all that apply)

	Self	***Family***	***Which Family Member***
Mental Illness	☐	☐	______________
Eating Disorder	☐	☐	______________
Alcoholism	☐	☐	______________
Substance Abuse	☐	☐	______________
Sexual Abuse	☐	☐	______________
Violent Behavior	☐	☐	______________
Suicide Attempt(s)	☐	☐	______________

HOW OFTEN TDO YOU...

	Never	*Daily*	*Weekly*	*Monthly*
Smoke				
Drink Alcohol				
Use Caffeine				
Use Marijuana				
Use Other Drugs (which?)				
Exercise (how?)				
Diet/Restrict your food intake				
Binge				
Purge (Laxatives/Self-induced vomiting/exercising)				
Self Harm (how?)				
Play an instrument				
Paint/draw/do arts & crafts				
Read				
Play board games or card games				
Do other hobbies (which?)				

PLEASE CHECK DIFFICULTIES YOU'VE EXPERIENCED IN THE FOLLOWING AREAS:

	Past	*Present*		*Past*	*Present*
Financial/unemployment			Low self-confidence		
Headaches			Feeling nervous/worry		
Unable to relax			Parent/child problems		
Feeling sad/depressed			Suicidal thoughts/actions		
Problems with spouse/partner			Drug/alcohol problems		
Self-harm			Body image struggles		
Fear of the future			Harming animals		
Spiritual/religious concerns			Frequent crying		
Anger/temper problems			Sleep problems/Insomnia		
Separation/Divorce			Unusual fears		
Nightmares			School Problems		
Loss of interest			Fatigue/exhaustion		
Sexual concerns			Eating Disorder		

Please describe your current concerns and issues for which you are seeking help:

____

____

____

Please describe your strengths/qualities about yourself and your life that you feel positively about:

____

____

____

If there is anything essential that you think we missed, please let us know:

____

____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE QUESTIONAIRE!

SIGNED: ____________________________________ **DATE:** ____________________