HAVEN

COUNSELING & COLLECTIVE

Intake Form

Please answer the following questions:

Client Information

NAME	AGE	DOB	GENDER
ADDRESS	CITY		ZIP
CELL #	RELATIONSHIP STATUS (married, single, divorced)		
ARE YOU A MEDICARE BENEFICIARY?	REFERRED FOR THERAPY BY:		

Medical Information

PRIMARY MEDICAL DOCTOR	TEL. #
LIST ALL PRESCRIPTION MEDICATIONS	

Emergency Information

EMERGENCY CONTACT	RELATIONSHIP TO YOU
TEL. #	CITY

Occupational/School Information

ARE YOU EMPLOYED?	EMPLOYER'S NAME
ARE YOU IN SCHOOL?	SCHOOL NAME

COUNSELING HISTORY

Have you ever been to a therapist before? How was that experience for you?

What brought you here today? What do you hope to gain from this experience?

Are you experiencing any of the following? (Check all that apply):

- □ sad mood/tearfulness
- □ no energy
- □ appetite changes
- □ guilt
- □ excessive worry
- □ obsessive thinking
- □ panic attacks
- □ phobias
- □ nightmares
- □ elated/manic mood
- □ impulsivity
- □ suicidal thoughts
- □ severe nausea
- □ sexual dysfunction
- □ other
- □ no pleasure
- □ sleep disturbances
- □ low self-esteem
- □ poor concentration
- □ intrusive thoughts
- □ compulsive behavior
- □ substance abuse
- □ compulsions
- □ flashbacks
- □ rapid speech
- □ hallucinations
- □ violent thoughts
- □ migraine headaches
- □ disordered eating

How have you attempted to cope with these issues? Please explain:

MEDICAL HISTORY

Have you experienced any of the following? Check all that apply:

- □ loss of consciousness
- □ hospitalizations
- □ headaches
- □ irritable bowel
- □ chest pain
- □ seizures
- □ fibromyalgia
- □ diabetes
- □ thyroid issues
- □ cancer
- □ allergies
- □ major accidents
- □ surgeries
- □ high blood pressure
- □ hormone related issues
- □ chronic pain
- □ compulsive behavior
- □ dizziness
- □ shortness of breath
- □ asthma
- □ numbness/tingling
- □ chronic illness

How much and how often do you consume alcohol?

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

OBSTETRIC HISTORY

How many times have you been pregnant?

How many full term deliveries (37+ weeks)?

How many preterm deliveries (20-37 weeks)?

How many miscarriages and/or still births?

How many living children do you have?

Have you had any difficulty getting pregnant? If so, please explain:

Have you had any other gynecological/obstetric issues?

PERINATAL HISTORY

Are you currently pregnant or trying to become pregnant? _____

If you are currently pregnant, was it planned?_____

Was this pregnancy desired?_____

Method of conception (natural or assisted)?_____

Estimated date of delivery? _____

Pregnancy complications? _____

Did you or your baby have complications at delivery? If yes, please explain:

_____

_____

_____

Have you experienced infant loss? _____

What methods are you/did you use to feed your baby?_____

Did you have any complications with breastfeeding? If yes, please describe:

_____

_____

Have you had or are you currently experiencing any thoughts that are scary to you about yourself or about your baby? If so, please describe:

_____

_____

FAMILY/SOCIAL SUPPORT

Who do you recognize as your support system?

_____

_____

Do you experience any family conflict or issues that concern you?

If you are currently in a relationship, how long have you been together? _____

SPIRITUAL/RELIGIOUS

Do you identify with any faith, spirituality, or church affiliation? If so, please explain:

CULTURAL/ETHNICITY

What is your ethnicity? Cultural heritage?

CONCLUSION

Is there anything else you would like me to know or that might be important?