# Counseling Arts & Wellness LLC
## Patient Information and Confidential History Intake

Name _____ Date _____
Address _____
Email _____ Phone _____ Referred by _____
Date of Birth _____ Age ____ Occupation _____
Can messages be left via phone and/or email? _____
Last year of school completed 9 10 11 12 College 1 2 3 4 Other _____
Currently in school Y N What level and what degree _____
Current Marital Status Single Engaged Married Separated Divorce Widow
Are you content with your current relationship situation? _____
If married, how long _____ Number of previous marriages _____
If separated or divorced for how long _____ If widowed _____
With whom do you currently live _____
Partner Name _____ How many years together _____
How would you describe this person _____
List your children, and ages _____
_____
List Mother, Father, Siblings _____
_____
_____
Primary Physician _____ Phone _____
Medications _____



*Underline the following physiological symptom if applies to you present/past:*
Headaches Past Present Difficulty Breathing Past Present Tiredness Past Present
Hearing voices/noises Past Present Visual disturbances Past Present Tension Past Present
*Circle if any of the following issues apply to you and/or your family: Y=you, F=family*
Stress Y F Panic Y F Guilt Y F Recent Death Y F Low Self-esteem Y F
Relationship Problems Y F Emotional Abuse Y F Physical Abuse Y F Addictions Y F
Anger Y F Career Y F Pornography Y F Legal Y F Intrusive Thoughts Y F
Nervous Y F Unhappiness Y F Grief Y F Verbal Abuse Y F Memory Y F Trauma Y F
Alcohol Y F Nicotine Y F Parenting Y F Self-Control Y F Sexual Trauma Y F
Finances Y F Compulsivity Y F Friends Y F Lonely Y F Depression Y F Anxiety Y F
Abortion Y F Aggressiveness Y F Eating Issues Y F Confusion Y F Other _____
LEVEL OF DISTRESS
Circle level of distress on this scale: 1 = Very Little 10 = Extreme
_____
_
1 2 3 4 5 6 7 8 9 10
Have you had any thoughts of suicide? Y N Have you ever attempted suicide? Y N

If so, when and how?

_____

_

WHY are you seeking professional counseling? _____

_____

_

_____

WHAT do you hope to gain from therapy? _____

_____

__

HOW long to you feel counseling will last? _____

_____

__



Have you ever sought previous counseling, if so when, with whom and for what purpose? _____

_____

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How would you describe yourself? _____

How would others describe you? _____

TERMS OF SERVICE

I understand that payment is due when services are rendered. I understand that I will be charged the office visit fee if a 24-hour notice is not given by either email or phone.

Patient _____ Date _____