

Helping My Clients Achieve Calm & Serenity

**Counseling Intake Form**

Name \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_

Birth date \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Marital status \_\_\_\_\_

Partner's name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Are you currently seeing a therapist or doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, therapist or doctor's name \_\_\_\_\_

Reason for treatment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of medication \_\_\_\_\_

Reason for taking medication \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, reason for hospitalization \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Initials

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**Counseling Intake Form (cont.)**

Have you ever been hospitalized for a mental illness?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, reason for hospitalization

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had previous therapy or counseling?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, reason for therapy or counseling

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Names and phone numbers of therapists

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Number of sessions and type of therapy

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Outcome of therapy

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope to achieve with this counseling? What is your most pressing issue?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Initials