

# Counseling Intake Form

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**CONFIDENTIAL**

## “Life History” Questionnaire

**Please fill out whatever is applicable to you.  
If you need more space for any answer, please use the back of the sheet.**

### General Information

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Male / Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ Work: \_\_\_\_\_  
Cell: \_\_\_\_\_ (E-mail) \_\_\_\_\_

Marital Status (circle one)

Single / Engaged    Married    Separated    Divorced    Widowed

Are you a student? Yes \_\_\_ No \_\_\_ Where? \_\_\_\_\_

Studying what? \_\_\_\_\_

Employed? Yes\_\_\_\_ No\_\_\_\_ Full Time/Part time \_\_\_\_\_

Employment Date \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Occupation \_\_\_\_\_

### **Presenting Problem**

Please state in your own words the main reason for seeking counseling.

On the scale below, please estimate the severity of your problems:

Mildly	Moderately	Very	Extremely	Totally
Upsetting____	Upsetting____	Upsetting____	Upsetting____	Upsetting____

When did your problems begin? Please give dates.

Please describe significant events occurring at the time, or since then, which may relate to the development or maintenance of your problems.

So far, what solutions to your problems have been most helpful?

Have you been in counseling before or received any professional assistance for these or other problems? If so, please give names, professional titles, dates of treatment and results.

Have you ever been hospitalized for psychological problems? Yes \_\_\_  
No \_\_\_ If yes, when and where?

### PERSONAL AND SOCIAL HISTORY

Siblings: Please list all of your siblings by sex, name, age and if they are still living. For those deceased, please give date and cause of death.

Male / Female	Name	Age	Living / Deceased	If deceased, date of death & cause

If your father is living, what is his age? \_\_\_\_ His occupation? \_\_\_\_\_

State of his health? \_\_\_\_\_

If your father is deceased, what was his age at the time of death? \_\_\_\_\_

How old were you at the time? \_\_\_\_ Cause of death? \_\_\_\_\_

If your mother is living, what is her age? \_\_\_\_ Her occupation? \_\_\_\_\_

If your mother is deceased, what was her age at the time of death? \_\_\_\_\_

How old were you at the time? \_\_\_\_ Cause of death? \_\_\_\_\_

**If applicable, please provide the following information**

Name of your Spouse (current) \_\_\_\_\_

Spouse's Age \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

When married? \_\_\_\_\_

How long did you know one another before your engagement? \_\_\_\_\_

Marital Status: Still married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Deceased \_\_\_\_

When? \_\_\_\_\_

**CHILDREN: Please list children by sex, name, and age.**

Male / Female	Name	Age	Living / Deceased	If deceased, date of death & cause

Name of your Spouse (former) \_\_\_\_\_

Spouse's Age \_\_\_ Spouse's occupation \_\_\_\_\_

When married? \_\_\_\_\_

How long did you know one another before your engagement? \_\_\_\_\_

Marital Status: Divorced \_\_\_ Deceased \_\_\_ When? \_\_\_\_\_

**CHILDREN: Please list children by sex, name, and age.**

Male / Female	Name	Age	Living / Deceased	If deceased, date of death & cause

**FRIENDS**

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? Yes \_\_\_ No \_\_\_

**RELIGION**

As a child? \_\_\_\_\_

As an adult? \_\_\_\_\_

## EDUCATION

Last grade completed? \_\_\_\_\_ Degree? \_\_\_\_\_

How would you describe your academic performance:

Excellent\_\_\_ Above Average\_\_\_ Average\_\_\_ Low Average\_\_\_ Poor\_\_\_

What were scholastic strengths and weakness?

Did you date much in high school? Yes\_\_\_ No\_\_\_

Did you date much in college? Yes\_\_\_ No\_\_\_

**Circle any of the following that applied during your childhood/adolescence:**

Happy Childhood	School Problems	Medical Problems
Unhappy childhood	Family Problems	Alcohol Abuse
Emotional / Behavior Problems	Strong Religious Convictions	Drug Abuse
Legal Problems	Other	

Do you have a family physician? If YES, please provide the following:

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Do you own a gun? Yes\_\_\_ No\_\_\_

Have you ever attempted suicide? Yes\_\_\_ No\_\_\_

Does any member of your family suffer from, Alcoholism, Epilepsy, Depression, Mental Disorders? If yes, please describe:

Has any relative attempted or committed suicide? Yes\_\_\_ No\_\_\_

Has any relative had serious problems with the law? Yes\_\_\_ No\_\_\_

## PHYSICAL SENSATIONS

**CIRCLE any of the following that often apply to you:**

Headaches	Stomach trouble	Skin Problems
Dizziness	Tics	Dry mouth
Palpitations	Fatigue	Burning or itchy skin
Muscle Spasms	Twitches	Chest pains
Tension	Back pain	Rapid heart beat
Sexual disturbance	Fainting spells	Blackouts
Bowel disturbances	Hearing things	Excessive sweating
Tingling	Watery eyes	Visual Disturbance
Numbness	Flushes	Hearing problems

**Female Clients please complete this section.**

### MENSTRUAL HISTORY

How old were you when you got your first period? \_\_\_\_\_

Were you informed or did it come as a shock? \_\_\_\_\_

Is your period regular? Yes \_\_\_ No \_\_\_

Do your periods affect your mood? Yes \_\_\_ No \_\_\_

Duration? \_\_\_\_\_ Date of last period? \_\_\_\_\_

Any relevant information about abortions or miscarriages? If yes, please describe:

## BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Yes\_\_ No\_\_  
If YES describe:

Are you currently taking medications? Yes\_\_ No\_\_  
If yes, please list any medications you are currently taking, or have taken during the past six months **include aspirin, birth control, prescription or over the counter medicines.**

**CIRCLE** any of the following that apply to you or members of your family

Thyroid disease    kidney disease    neurological diseases    asthma  
Diabetes            cancer                    epilepsy    gastrointestinal disease  
Glaucoma            prostate problems        Other\_\_\_\_\_

Are you currently (or have ever been) in an abusive relationship? Yes\_\_ No\_\_

Have you had accidents or injuries not previously describe? Yes\_\_ No\_\_  
If yes, please provide details and dates:

Have you ever had any head injuries or loss of consciousness? Yes\_\_ No\_\_  
If yes, please give details and dates:

Have you had surgery? Yes\_\_ No\_\_  
If yes, please give details and dates:

**CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU**

	NEVER	RARELY	FREQUENTLY	VERY OFTEN
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens, LSD				
Diarrhea				
Constipation				
Allergies				
High Blood Pressure				
Heart Problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early Morning Awakening				
Fitful Sleep				
Overeat				
Poor Appetite				
Eat "Junk Foods"				

## FINANCIAL POLICY

Please take a few minutes to read this to avoid misunderstandings about payment. **Payment is always expected and required at the time of your visit.** You may pay cash, check or Visa, MasterCard or American Express. If you would like to automatically use your credit card as payment each time you come, you will need to complete the portion of this form below. Checks returned by your bank are subject to a **\$ 20.00 processing** charge. Accounts unpaid after **30 days** from the date of billing may be subject to a finance charge at the rate of **0.5% per month (6% per annum)**. Accounts with an outstanding balance of **90 days are automatically referred for collection**. If your account must be referred to an outside agency for collection, you will be responsible for collection costs up to **30%** of the outstanding balance, together with court costs and reasonable attorney's fees.

If you are not able to keep a scheduled appointment and do not give at least 24 hours notice or fail to show up for your scheduled appointment, you are subject to being charged for the missed appointment. If you are a member of a group, **you will be billed for every session the group convenes whether you attend or not.**

We would like to take this opportunity to welcome you and assure you that we will do our utmost to provide you with the best care possible.

### I have read and understand the Financial Policy.

Client Name: \_\_\_\_\_

Please Print

Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client or Responsible Individual

\*\*\*\*\*OPTIONAL\*\*\*\*\*

### CREDIT CARD AUTHORIZATION

**I authorize you to bill my credit card at the time of my visit.**

Name as it appears on card: \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

3 digit security code on back of card: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_