Full Circle Counseling Client Intake Form

This information is confidential and protected under Federal Law. It cannot be released without you written consent. Please answer the questions thoughtfully and truthfully.

Date:_____ Email Address:_____

How did you hear about Full Circle? _____

Your Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone # Cell:_____Work:_____ Home:_____

Can I leave a message on your: Voice Mail? Cell? Work? Home? Email? Text?

Insurance ID#:_____ Group #:_____

Name of Insurance Co.: _____

Insurance Co. Phone #:_____

Age:_____DOB:_____

Emergency Contact:_____Relationship:_____

Address:_____ City:_____ State:____ Zip:_____

Phone # Cell:_____Work:_____ Home:_____

What Symptoms or situations have prompted you to seek counseling?_____

_____

Medical Information:

Are you currently being treated for any medical condition? If so please describe.

_____

Medications:

Please list all medications and herbal supplements and why you are using them:

_____

Mental Status:

Have you ever seen a therapist or other mental health provider prior to coming here?_____

What were you treated for and when did you see that provider?_____

_____

Are you currently receiving mental health services elsewhere?_____

Have you heard or seen things that others do not?_____

Do you hear voices or noises in your head that you cannot control?_____

Do you ever have experiences or thoughts that seem strange to others?_____

Do you have a history of: Depression? Anxiety? Addiction?

Have you ever experienced any significant trauma or abuse as a child or adult?_____

Was it reported? When and to whom?_____

Has anyone in your family been diagnosed with a mental disorder or addiction?_____

If so, who and what?_____

Have you ever or do you currently self-injure? Such as cutting, "carving" sticking pins in your skin, pulling out eyelashes, pulling out your hair, bulimia, etc._____

Have you ever thought about ending your life or contemplating suicide?_____
Have you ever attempted suicide?_____

If so, when, how did you attempt and were you hospitalized?_____

Are you thinking about Suicide or ending your life now?_____

Were you ever hospitalized for a psychiatric condition?_____

Have you ever had thoughts of wanting to kill or harm others?_____

Substance Use:

Please state which substances you currently use, how much and frequency:

Caffeine_____

Tobacco_____

Alcohol_____

Marijuana_____

Amphetamines or Diet Pills_____

Cocaine_____

Inhalants_____

Hallucinogens or Ecstasy_____

Opiates (Heroin/Methadone)_____

Prescription Pills (Oxycdone, Xanax, Vicodin, etc.)_____

Have you ever had an eating disorder?_____

Do you gamble? How much, how often?_____

Have you ever gambled more than you intended to?_____

Has anyone ever complained about your gambling?_____

Do you have concerns about your sexual behaviors, performance or identity?_____

_____

Legal History:

Have you ever been arrested?_____

Are you involved in any legal issues currently?_____

Family Information:

Who is living in your home now?_____

How many children do you have?_____

How many times have you been married?_____

If not married do you have a Significant Other?_____

Who are the important people in your life now?_____

Activities:

Do you have an active social life?_____

What are your hobbies?_____

Educational History:

Highest Level of Education_____Major_____

Employment:

Are you satisfied with your job?_____

How long have you been with your current employer and what do you do?_____

_____

Motivation Level:

On a scale of one to ten, ten being the highest, how much do you believe that your problems will get better? 1 2 3 4 5 6 7 8 9 10

On a scale of one to ten, ten being the highest, how motivated are you to participate in counseling and get better? 1 2 3 4 5 6 7 8 9 10

What things have you tried in the past that have helped your symptoms or problems?

_____

Describe the last time you felt really happy or content with your life. What was happening at that time? Who was in your life?_____

_____

Describe your spirituality if any._____

What else should I know about you that will help me to help you get better?_____

_____

Please sign acknowledging that you have received the Professional Disclosure Statement for Elizabeth Hartshorn LPC and Informed Consent

Signature_____ Date_____