

Cardia Counseling Center, Inc.

Confidential Intake Form

Name: _____ Date: _____

Address: _____

May we send newsletter to this address? Yes ___ No ___

Telephone: (H) _____ (W) _____

(C) _____ Where can a private message be left? H ___ W ___ C ___

Email Address: _____

Emergency Contact (Name, address, phone, relationship):

Gender: Male ___ Female ___ Age: ___ Date of birth: ___/___/___

Marital Status: _____

Name, age, and your relationship to the people in your family. Please include former spouses and any significant relationships of which your counselor should be aware:

Occupation: _____

History:

Previous Counseling: Yes ___ No ___

When: _____

Where: _____

Length of counseling: _____

Reason for counseling at that time: _____

Current Medical Conditions: _____

Current medications: _____

Name of prescribing doctor: _____

S/he is a ___ Medical Doctor or ___ Psychiatrist

Referral information:

Referral Name: _____

Address: _____

Phone: _____

May I contact them to thank them for the referral? Yes ___ No ___

Primary concerns:

Symptom/Behavior Checklist (check all that apply, circle worst symptoms/behavior)

Depressed Mood	_____	Decreased Energy/Fatigue	_____
Lack of Motivation/Interest	_____	Irritability	_____
Guilt	_____	Worthlessness	_____
Difficulty Sleeping	_____	Over-Sleeping	_____
Difficulty Eating	_____	Over-Eating	_____
Tearfulness	_____	Helplessness/Hopelessness	_____

Thoughts of Death/Suicide _____ Suicide Threats/Attempts _____

Anxious Mood	_____	Racing Thoughts	_____
Concentration Problems	_____	Forgetfulness	_____
Worry	_____	Restlessness/Jumpiness	_____
Racing Heart	_____	Shortness of Breath	_____
Muscle Tension	_____	Panic Attacks	_____

Inattention	_____	Hyperactivity	_____
Impulsivity	_____	Suspiciousness	_____
Scary Thoughts	_____	Scary Experiences	_____
Anger/Aggression	_____	Fear for Safety	_____

Compulsive Behaviors: Spending _____ Sex _____ Cleaning _____ Work _____ Gambling _____ Other _____

Substances Used: Tobacco _____ Caffeine _____ Alcohol _____ Illegal Drugs _____ Non-Prescription Drugs _____

Please Describe _____

History of Substance Abuse Problems _____

Reason for seeking counseling at this time: _____
