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:_____

_____

_____