Confidential Individual Counseling Intake Form

Please fill out this form to help us know more about you and to ensure your counseling sessions focus on what is most important to you. Information provided is confidential as outlined in the Professional Disclosure Statement, the counseling office policies, and HIPPA Notice of Privacy posted online at pillarsofhopecounseling.com. We would be happy to discuss those with you.

Name_____Date_____

Address _____City/ State_____ Zip_____

Contact # _____Alternative # _____

OK to leave messages at these phone numbers? ☐ Yes ☐ No OK to text these numbers? ☐ Yes ☐ No
*Please note email and/or texting is not considered confidential communication.

Email_____

Date & Place of Birth _____Age_____ Gender: ☐ F ☐ M

Your current marital status: ☐Never Married ☐Married ☐Partnered ☐Separated ☐Widowed ☐Divorced
List past and present significant relationships _____

_____

List family and friends you count on for support_____

_____

Are you currently attending school? ☐ Yes ☐ No Please check all degrees earned from the list below.

☐ High School Diploma or ☐ GED Year _____

☐ Associates Degree Year _____ Area of study_____

☐ Undergraduate Degree Year _____ Area of study_____

☐ Master Degree Year _____ Area of study _____

☐ PhD Degree Year _____ Area of study _____

Current Employer _____Position_____Length of Service _____

Do you find your work enjoyable? ☐ Yes ☐ No Are finances a major stressor? ☐ Yes ☐ No

Military History: ☐N/A ☐Current ☐Discharged (If currently serving or discharged) Rank_____

Branch _____ Date of Discharge _____ Were you in combat? ☐ Yes ☐ No

Are you involved in any current or pending civil or criminal litigation/s, lawsuits, divorce proceedings, or custody disputes?
☐ Yes ☐ No (If "yes" please explain) _____

_____

Emergency contact person_____ Relationship _____

Referral source or how you came here: _____

Have you experienced any of the following medical conditions during your lifetime?

☐Abortion ☐Allergies ☐Asthma ☐Chronic Pain ☐Diabetes

☐Dizziness ☐Fainting ☐Headaches ☐Head Injury ☐Hearing Problems

☐High Fevers ☐Meningitis ☐Miscarriages ☐Seizures ☐Serious Accident

☐Sleep Disorders ☐Stomach Aches ☐Surgery ☐Vision Problems ☐Other

List any additional health concerns _____ Date of last physical _____

List current medications:

Medication	Dosage	Start Date

Describe any past or present drug/ alcohol use/abuse or treatments. _____

_____

Describe any suicide attempts or violent behavior._____

_____

Please check *all* that apply:

☐Abuse ☐Abandonment ☐Adjustment concerns ☐Appetite or eating issues

☐Anger ☐Anxiety or worry ☐Career concerns ☐Communication

☐Depression ☐Divorce ☐Downsizing /Layoff ☐Emotional Abuse

☐Fears or Phobias ☐Financial Abuse ☐Grief or Loss ☐Image concerns

☐Infidelity ☐Intimate Partner Violence ☐Isolation ☐Loneliness

☐Marital Unrest ☐Mood Swings ☐Nervousness ☐Obsessions or compulsions

☐Posttraumatic Stress ☐Recurring Thoughts ☐Relationship concerns ☐Role Adjustment concerns

☐Self-Esteem ☐Sexual Abuse ☐Sleep concerns ☐Social Anxiety

☐Spiritual concerns ☐Substance Abuse ☐Suicidal Thoughts ☐Trauma

Have you received counseling before? ☐ Yes ☐ No (If "yes" please provide the reason and with whom) _____

_____

Have you been previously diagnosed with a mental disorder? ☐ Yes ☐ No (If "yes" please explain) _____

_____

What do you wish to accomplish in counseling? _____

_____

How long has this been troubling you? _____ Please indicate severity: ☐Mild ☐Moderate ☐Serious

Thank you for completing this form