Above It All Counseling Group

Intake Form

Please complete all information on this form and bring it to the first visit. All information is confidential and between you and your clinician. If you are requesting for this information to be released, please let your clinician know and they will discuss this with you further.

Name_____Date_____

Address: _____

Date of Birth _____ Current age: _____ Phone: _____

Email: _____

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

Name of current employer: _____

Have you ever served in the military? ( ) Yes ( ) No If so, what branch and when? _____

_____

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Emergency Contact List

Name:_____Relationship: _____

Address: _____

City:_____ State: _____Zip Code: _____

Phone: _____

Financially Responsible Person Information

Need for Insurance reimbursement letter ☐ yes ☐ no

First Name:_____ MI: _____ Last Name: _____

Date of Birth:_____ Social Security #: _____

Address:_____

City:_____ State: _____ Zip code:_____

Phone: _____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

	Depressed mood		Avoidance		Hallucinations		Anxiety attacks		Isolating self
	Racing thoughts		Loss of interest		Excessive energy		Aggressive towards others		Restless
	Excessive worry		Excessive guilt		Decrease need for sleep		Increased anger or irritability		Mood swings
	Unable to enjoy activities		Concentration/ forgetfulness		Change in appetite		Sleep pattern disturbance		Numbness
	Impulsivity		Nightmares		Increased libido		Suspiciousness		Worthlessness
	Crying spells		Fatigue		Decreased libido		Increase risky behavior		Self-harm behaviors

Trauma History:

Yes	No	Do you have a history of being abused? If so please state age and by whom.
		Neglect
		Emotionally
		Physically
		Sexual

Suicide Risk Assessment: Have you experienced thoughts of suicide in the last 24 hours? ( ) Yes ( ) No
Do you have a current plan to commit suicide? ( ) Yes ( ) No
Have you had any recent suicide attempts? ( ) Yes ( ) No When: _____

Medical History:

Current Medical Conditions: _____

Allergies: _____

List **ALL** current prescription medications and how often you take them: _____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Do you have any concerns about your physical health that you would like to discuss? ( ) Yes ( ) No

Personal and Family Medical History:

You	Family		Y	F		Y	F	
		Thyroid Disease			Diabetes			Chronic pain
		Anemia			Asthma/respiratory problems			Chronic fatigue
		Kidney Disease			Heart Disease			Chronic headaches
		Liver Disease			High blood pressure			Migraines
		Liver problems			Epilepsy or seizures			Head trauma
		Cancer			Stomach or intestinal problems			Other:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, describe (when, by whom, and nature of treatment): _____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe (reason, date, where): _____

_____

Previous Diagnosis: _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for mental health issues: _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

Are you currently using any substances? ( ) Yes ( ) No If yes, describe (substance, frequency, and amount): _____

Additional Information:

Is there anything else that you would like us to know?

_____

_____

_____

_____

Signature: _____ Date: _____

Guardian Signature (if under 18): _____ Date: _____

For Office Use Only:

Reviewed by: _____ Date: _____