Paul Elmore Counseling Intake Form

Case #

The information obtained on this form is confidential and will be used exclusively for the counseling services obtained from Paul Elmore. **PLEASE PRINT. Use N/A if not applicable.**

CLIENT PERSONAL INFORMATION

Today's Date

Name (Client)	Date of Birth	Age	SSN
Parents/Guardian of Client (if client is a minor)	Emergency Contact & Phone (Other than parent/guardian)		
Address	City	State	Zip
Home Phone: May we leave a message? ○Yes ○No	Cell/Other Phone: May we leave a message? ○Yes ○No		
Email: May we leave a message? ○Yes ○No (Note: Email is not considered confidential)			
Occupation / Employer	Marital Status ○Single ○Married ○Separated ○Divorced ○Widowed		

SERVICES INFORMATION

Name of person or agency that referred you

Have you ever received prior counseling? ○Yes ○No
When?

Check which services you are requesting
○ Individual Counseling ○ Couples Counseling ○ Family Counseling ○ One-time Assessment ○ Consultation

Please describe the issue for which you are seeking counseling.

Please check all that apply

○ Mood Swings	○ Marriage Problems	○ Fears	○ Emotional Extremes
○ Lack of Energy	○ School Problems	○ Confusion	○ Unusual Experiences
○ Excess Energy	○ Alcohol/Drug Problems	○ Too Little Sleep	○ Memory Problems
○ Racing Thoughts	○ Sexual Acting-out/Addiction	○ Too Much Sleep	○ Unsure of Reality
○ Slowed Thinking	○ Wish to Die	○ Angry Feelings	○ Unsure Identity
○ Guilt Feelings (Strong)	○ Thoughts of Suicide	○ Panic Attacks	
○ Guilt Feelings (Light)	○ Suicide Attempts	○ Occupational Problems	

FAMILY INFORMATION

Please list the members of your immediate family:

Name	Sex	Age

Has your family ever participated in family therapy? ○Yes ○No

Check any past, present or impending issues in your Family of Origin:

○ Deaths	○ Physical Abuse
○ Divorces	○ Sexual Abuse
○ Frequent Relocation	○ Financial Crisis/Unemployment
○ Debilitating Injuries/Disabilities	○ Legal Problems
○ Alcohol/Drug Use	○ Attempted/Completed Suicide
○ Serious Illness	○ Other
○ Psychiatric Disorder	

MEDICAL HISTORY & INFORMATION

How is your current physical health?
○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very Good ○ Other (Describe)

Are you currently on any prescribed medications? ○Yes ○No
If 'Yes' please list:

Do you use recreational drugs? ○Yes ○No
If 'Yes' please list:

Do you regularly consume alcohol? ○Yes ○No

Do you consider your alcohol use a problem? ○Yes ○No

Please list any persistent physical symptoms or health concerns (headaches, chronic pain, diabetes, etc…)

Have you had suicidal thoughts recently?
○ Frequently ○ Sometimes ○ Rarely ○ Never

Have you had suicidal thoughts in the past?
○ Frequently ○Sometimes ○ Rarely ○ Never

Have you ever intentionally inflicted harm upon yourself? ○Yes ○No ○Unsure
If 'Yes' please describe:

Is there any other medical history or condition that would be important for your counselor to know? ○Yes ○No
If 'Yes' please explain: