Healthy Outlook Counseling

276 South Main St.
Colchester, CT 06415
(860) 917-8316

Intake Form

Welcome to Healthy Outlook Counseling. Please help us make the most of our first meeting with you by providing some information in advance of your first appointment. Please fill out the following as completely and legibly as possible. This information is confidential. If you are uncomfortable answering any question and wish to leave it blank, please feel free to do so.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Primary Phone: _____ May we leave a voice message at this number? Yes/No

Secondary Phone: _____ May we leave a voice message at this number? Yes/No

Email: _____ May we email you? Yes/No

Emergency Contact: _____ Phone: _____

Primary Insurance: _____ Insurance ID#: _____

Insurance Subscriber Name: _____ Subscriber DOB: _____

Highest Level of Education Completed: _____ Are you currently a student? Yes/No

Current Occupation: _____ Race/Ethnicity: _____

Religious/Spiritual Faith: _____ Relationship Status: _____

Do you have any children? Yes/No If yes, list ages: _____

Who currently lives in your household? _____

_____

How did you find out about Healthy Outlook Counseling? _____

What brings you to therapy at this time? _____

_____

_____

_____

_____

What do you hope to get out of therapy? What are your goals for therapy? _____

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_____

Primary Care Physician: _____ Phone: _____

Please list any current medical problems: _____

_____

_____

_____

Please list all medications you take including prescription, over the counter, vitamins and supplements:

_____

_____

Please describe any mental health or substance related services that you are currently receiving including names of providers: _____

_____

_____

Please describe any previous services you have received for mental health or substance related problems: _____

_____

_____

_____

Please list any mental health or substance related diagnoses you have been given: _____

_____

_____

Please describe your family history of mental health and substance related problems: _____

_____

_____

_____

Please list all substances including alcohol that you have used in the last year and indicate frequency and typical amount used: _____

_____

_____

_____

Please circle all items below that describe your experiences with alcohol or substance use:

using more than intended	trying to cut back use		using in physically hazardous situations	
tolerance to substance	withdrawal from substance	craving	lots of time spent related to use	
substance use related problems:	at work	at school	at home	in relationships
	with physical health		with mental health	

Please describe any current or past legal problems such as probation, arrest, incarceration, divorce, custody issues, DCF involvement and restraining orders: _____

_____

_____

Have you ever had suicidal or homicidal thoughts? _____ If yes, please describe

_____

_____

_____

Have you ever injured yourself on purpose or attempted suicide? _____ If yes, please describe

_____

_____

Please rate your how stressed you feel lately from 1-10 (1=none, 10=severe): _____

Please describe your current sources of stress: _____

_____

_____

_____

Please circle all current areas of concern:

abuse experience	anger	anxiety/nervousness	body image
compulsive behavior	concentration/attention	conflicts with others	crying
depressed mood	eating/appetite	emotional numbing	excessive energy
fatigue	fears	finances	gambling
gender identity	grief	guilt	headaches
health	hyperactivity	impulsivity	irritability
learning disability	low energy	making decisions	memory
mood swings	muscle tension	obsessive thoughts	panic attacks
parenting	physical pain	relationships	sadness
school	self-esteem	sex/sexuality	sleep
stomachaches	stress	thoughts of death	traumatic experience
unusual beliefs	violence	work	worry
perceiving things that others do not			

Feel free to share additional information about concerns or other comments: _____

_____

_____

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