Lauren Pellizzi LLC
Licensed Professional Counselor
(732) 705-1882

COUNSELING INTAKE FORM

Note: This information is confidential.

DEMOGRAPHIC INFORMATION		
Name:	Date:	☐ M ☐ F ☐ Other
Email:	Age:	DOB:
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N	
Work Phone:	Is it ok to leave a message for you at this number? Y / N	
Mailing Address:		
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Religion:	Sexual Orientation:	
How much does religion affect your daily life? (None) 0 1 2 3 4 5 (Very much)		
How were you referred?		
If online, which website?		

EMERGENCY CONTACT INFORMATION	
Name:	Address:
Phone:	
Relationship to client:	

EMPLOYMENT STATUS	
☐ I am self-employed ☐ I am unemployed ☐ I am retired ☐ I am a student ☐ I am on disability	
Occupation:	☐ Full time ☐ Part time
Employer/company:	Highest level of education:

LEGAL HISTORY		
Have you ever been incarcerated (jail or prison)? ☐ YES ☐ NO		
Reason for incarceration:		
Have you ever had a DUI/DWI?	☐ YES ☐ NO	HOW MANY:
Are you currently on Probation?	☐ YES ☐ NO	

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MEDICAL HISTORY	
Primary Care Physician:	Phone:
Psychiatrist:	Phone:
List any medical problems and recent surgeries:	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

PSYCHIATRIC HISTORY

Psychiatric Hospitalizations and/or Residential Treatment

Year	Reason	Hospital

Past outpatient treatment (i.e. therapist, psychiatrist, group therapy)

Year	Reason	Treatment Provider

Have you ever attempted suicide?
Are you currently having thoughts of suicide?
Have you ever suffered from an eating disorder?

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FAMILY HISTORY
Has a relative ever been diagnosed with a mental illness?
If yes, describe:
Has anyone in your family ever attempted or completed suicide?
If yes, describe:
Does anyone in your family have a substance abuse problem?

ALCOHOL AND DRUG HISTORY

Please check which of the following substances you have used or currently are using:

Substance	When use began?	Used in past year?	How often?
Alcohol			
Inhalants			
Marijuana			
Amphetamines			
Barbiturates			
Valium, Xanax, etc.			
Psychedelics			
Crack/Cocaine			
Heroin			
Opiate pain medication			
Synthetic drugs (K2, Spice)			
Over the counter medication			
Other:			

Have you ever felt you should cut down on your drinking and/or drug use? ☐ YES ☐ NO

Have people annoyed you by criticizing your drinking and/or drug use? ☐ YES ☐ NO

Have you ever felt bad or guilty about your drinking and/or drug use? ☐ YES ☐ NO

Have you ever used alcohol or drugs in the morning to steady your nerves or get rid of a hang-over? ☐ YES ☐ NO

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Have you ever had any drug or alcohol related arrests? ☐ YES ☐ NO

Have you experienced any blackouts from drugs or alcohol? ☐ YES ☐ NO

Have you ever been in treatment for Chemical Dependency/Addiction?

If Yes, where and when_____

Treatment was for which substance(s) _____

Are you currently involved in a recovery program? ☐ YES ☐ NO Do you attend meetings? ☐ YES ☐ NO

Do you have a sponsor? ☐ YES ☐ NO