Illuminate Counseling Intake Form

Demographic Information:

Name _____ Today's Date _____

Preferred Name _____ Date of Birth ___/___/_____

Address _____

_____

Primary Phone # _____ H C W

Is it okay to leave a voice message or text message for you at this number? Y / N

Alternate Phone # _____ H C W

Is it okay to leave a voice message or text message for you at this number? Y / N

Email _____ Social Security # _____

Emergency Contact _____

Address _____

_____

Phone # _____ Relationship _____

Current Occupational Status _____

Current Relationship Status _____

How were you referred? _____

Health Information:

How would you rate your overall health? _____

Have you been diagnosed with any physical conditions? _____

Have you ever received a mental health diagnosis? _____

Have you experienced any of the following behaviors or symptoms within the past 6 months:

Change in eating patterns	Change in sleep patterns	Suicide attempts	Fatigue
Lack of motivation	Drinking too much	Frequent crying	
Feeling of isolation	Angry outbursts	Headaches	

What medications are currently taking (including over-the-counter) _____

_____

_____

Do you exercise regularly? If so, what type and how frequently? _____

_____

Current Concerns:

What are the primary concerns that are bringing you in to counseling at this time? _____

_____

_____

_____

_____

_____

What do you hope to accomplish in counseling? _____

_____

_____

_____

_____

What obstacles do you think might get in the way of what you would like to accomplish? _____

_____

_____

_____

_____

What strengths do you possess that will help you to overcome the obstacles in your path? _____

_____

_____

_____

_____