HOPE In Home Counseling
PERSONAL INTAKE INFORMATION

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Date_____ Name_____

Address_____ City_____ Zip_____

Phone_____- Is it ok to leave messages at this number?_____

DOB_____ Age_____ Siblings_____ Your Birth Order_____

Highest Level of Education_____ Occupation_____

Marital Status_____ Spouse's Name_____ DOB_____

Marriage Date_____ Separation_____ Divorce_____ Widowed_____

Children? Yes or No If Yes, Please list gender and age of each child and whether the child lives with you. _____

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Denomination Preference?_____ Do you currently have support system in the community? Yes or No IE- church, friends, support groups

Previous Counseling? Yes or No If Yes, dates and briefly explain reason and resolution

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Any current medical issues? Yes or No If yes, please indicate

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Alcohol use Tobacco Please list current medications:

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Please describe briefly the reason you are seeking counseling at this point in your life

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Have you experienced a recent loss or stressor? Yes No Please Explain

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Please check if you are experiencing any of the following symptoms:

Anxiety_____ Uncontrollable Crying_____ Quick Temper_____

Increase/Decrease Weight Loss_____ Panic Attacks_____ Sadness_____

Increase/Decrease Sleep_____ Suicidal Thoughts_____ Decrease Energy____

Signature and Today's Date_____