PATHWAYS to HEALING
counseling

PATHWAYS TO HEALING COUNSELING, LLC
INTAKE FORM

Please provide the following information by answering the questions below and bring it to your first session. Information provided is protected as confidential information. If participating as a couple, each individual needs to complete this form.

Name_____ Maiden Name_____
(Last) (First) (Middle Initial)

Name of Parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Age_____ Date of Birth _____/_____/_____ Gender: ☐ Male ☐ Female

Soc. Sec.#_____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Address _____
Street Apt. City State Zip

Home Phone: (_____)_____ May we leave a message? ☐Yes ☐No

Cell Phone: (_____)_____May we leave a message & text you?
*Please note text messaging is not considered to be a confidential medium of communication.
☐Yes ☐No

Work Phone: (_____)_____ext.____ May we leave a message? ☐Yes ☐No

E-mail_____ May we e-mail you? ☐Yes ☐No
*Please note e-mail correspondence is not considered to be a confidential medium of communication.

Employer (or school or grade) & Title or position of client_____

Education (last year completed or degree) _____

Person, agency or other referral source or how you heard about us (e.g., Internet, Psychology Today, doctor):
_____

Physician_____Address & Phone_____

Previous counseling or psychiatrist experience:

_____

Where or with whom Dates

In case of emergency, contact: _____

Name Relationship Phone Number(s)

Marriage and Family Information (if applicable):

Spouse_____ Age_____ Date of Birth_____

Employer & Position _____

Education (last year completed or degree)_____

Date of Marriage _____ Length of dating relationship _____

Give a brief statement re: circumstances of meeting and dating.

_____

_____

List your children:

Name_____ Male/Female Age_____

Name_____ Male/Female Age_____

Name_____ Male/Female Age_____

Name_____ Male/Female Age_____

General Health:

1. Describe your health_____

2. Do you have any chronic conditions? Y/N If yes, please list_____

3. Current medications and dosage_____

_____

4. Have you ever been prescribed psychiatric medication? Y/N
If yes, please list and provide dates_____

5. Do you drink alcoholic beverages? Y/N If yes, how frequently and how much_____

6. Do you currently or have you in the past used drugs other than for medical purposes? Y/N
If yes, please describe_____

7. Have you ever had a *severe* emotional upset? Y/N If yes, please explain_____

8. How many hours per week do you generally exercise? _____

9. If you exercise, what types of exercise do you participate in?_____

10. List any specific sleep issues you are currently having_____

Emotional Health:
Please CIRCLE any of the following words which best describe you now:

Active Ambitious Moody Self-Confident Persistent Nervous

Hardworking Impatient Impulsive Kind Often-blue Excitable

Imaginative Calm Serious Easy-going Shy Good-natured

Introvert Extrovert Likeable Leader Quiet Angry Fearful

Submissive Spiritual Self-conscious Lonely Sensitive Anxious

Regimented Obsessive

Issue Check List

___Anger	___Envy	___Appetite	____Anxiety
___Fear	___Memory	___Apathy	____Moodiness
___Bitterness	___Guilt	___Rebellion	____Health
___Sex	___Children	___Addiction	____Depression
___Work	___Impotence	___Abuse	____Deception
___In-laws	___Grief	___Eating Disorder	____Chronic Illness
___Blended Family	___Panic Attacks	___Change in lifestyle	____Sadness

Family History:
In the section below, identify if there is a family history, of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, mother, maternal grandmother, uncle, etc.) or if you have struggled with any of the below.

	Please Circle	**List Family Member and/or Yourself**
Alcohol/Substance Abuse/Addiction	Y/N	
Post Traumatic Stress Disorder	Y/N	
Anxiety	Y/N	
Adoption	Y/N	
Depression	Y/N	
Divorce	Y/N	
Domestic Violence	Y/N	
Hoarding	Y/N	
Eating Disorders	Y/N	
Suicide Attempts	Y/N	
Obesity	Y/N	
Emotional Abuse	Y/N	
Obsessive Compulsive Behavior	Y/N	

Psychiatric Hospitalizations	Y/N
Abandonment by parent	Y/N
Sexual Abuse	Y/N
Other Traumas (please list specifically):	

Briefly answer the following questions:

1. What brings you to counseling?

2. What have you already tried to do about this?

3. What do you hope to specifically accomplish through your counseling experience?

4. What do you consider your strengths?

5. What do you consider your weaknesses?

6. Do you consider yourself to be spiritual or religious? If so, briefly describe your faith or beliefs.

7. Is there any other information that is important for the counselor to know?

Client(s):

_____	_____	_____
Printed Name of Client	Signature of Client	Date
_____	_____	_____
Printed Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian (If client is under 18)	Date
_____	_____	_____
Printed Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian (If client is under 18)	Date