
Birds of a Feather Counseling Intake Form

Walter Rhoads

Birds of a Feather Counseling

1110 North West End Blvd., Quakertown, PA 18951

## CLIENT INTAKE FORM

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy sessions.

First, Last, Middle Initial _____

Name of parent or guardian (if minor):

_____

Birth date: _____/_____/_____ Age: _____

Gender: ____Male ____Female ____Other: _____

Marital status: ___Single ___Partnered ___Married ___Separated ___Divorced ___Widowed

Do you have children? Yes/No

If Yes, How many and what are their ages:

_____

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ May we leave a message? Yes / No

Cell/other: _____ May we leave a message? Yes / No

Email: _____

May we email you?* Yes / No

**NOTE: Emails may not be confidential.*

Referred by: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes / No

Reason for change: _____

Have you had any mental health services in the past? Yes / No

Reason for change:

_____

Are you currently taking any psychiatric prescription medication? Yes / No

If yes, please list:

_____

Have you been prescribed psychiatric prescription medication in the past? Yes / No

If yes, please list:

_____

**General Health Information**

How would you describe your physical health at the present time?

____Poor ____Unsatisfactory ____Satisfactory ____ Good ____ Very good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____

_____

_____

Are you on any medication for physical/medical issues? Yes / No

If yes, please list: _____

Are you having any problems with your quality of sleep? Yes / No

If yes, check those that apply:

Sleep too much ____ Sleep too little ____

Poor quality ____ Disturbing dreams ___

Other: _____

How many times per week do you exercise? _____ days _____ minutes / hours

Are there any changes or difficulties with your eating habits? Yes / No

If yes, check those that apply:

____Eating less ____Eating more ____Bingeing ____Restricting ____Other: _____

Have you experienced a weight change in the last two months? Yes / No

If yes, describe:

_____

Do you consume alcohol regularly? Yes / No

In one month, how many times do you have four or more drinks in a 24-hour period? _____
How often do you engage in recreational drug use?

___Daily ___Weekly ___Monthly ___Rarely ___Never

If Yes, what types of drugs?_____

Have you felt depressed recently? Yes / No

If yes, for how long?

_____

Have you had any suicidal thoughts recently? Yes / No

If yes, how often? ___Frequently ___ Sometimes ___ Rarely

Have you ever had suicidal thoughts in the past? Yes / No

If yes, how long ago?

_____

How often did you have these thoughts? ___Frequently ___ Sometimes ___ Rarely

Are you currently in a romantic relationship? Yes / No

If yes, how long have you been in this relationship? _____

On a scale from 1 to 10 (10 being great, 1 being poor), how would you rate the quality of your relationship? _____

In the last year, have you experienced any major life changes (employment, relocation,

relationship, illness, loss of loved one, etc.)? Describe.

_____

_____

_____

Check off the issues below that apply to you:

___ Extreme depressed mood ___ Mood swings ___ Extreme anxiety ___ Panic attacks ___ Phobias ___ Sleep disturbance ___ Hallucinations ___ Memory problems ___ Body complaints ___ Alcohol/substance abuse ___ Body complaints ___ Eating disorder ___ Repetitive thoughts ___ Anxiety ___ Time loss ___ Repetitive behaviors ___ Homicidal thoughts ___ Indecision ___ Suicide attempts ___ Trouble planning ___ Lack of focus ___ Difficulty with relationships ___ Confusion ___ Anger issues

**Sexual History**

How did you learn about sex?

_____

_____

_____

_____

How old were you when you began dating/sexuall active? _____

Describe your first sexual experience.

_____

_____

_____

_____

Were you ever sexually abused? Yes / No

_____

_____

**Occupational Information**

Are you currently employed? Yes / No

If yes, who is your employer?

_____

What is your position?

_____

Are you happy in your current position? Yes / No

Are you fulfilled in your current position? Yes / No

Does your work make you stressed? Yes / No

If yes, what are your work-related stressors? _____

**Religious/Spiritual Information**

Do you practice or observe a religion? Yes / No

If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? Yes / No

**Family Mental Health History**

Please provide information about your family history. Circle yes or no. If yes, please indicate the family member/relationship affected.

Depression Yes / No _____

Anxiety Disorders Yes / No _____

Bipolar Disorder Yes / No _____

Panic Attacks Yes / No _____

Alcohol Abuse Yes / No _____

Drug Abuse Yes / No _____

Eating Disorder Yes / No _____

Learning Disability Yes / No _____

Trauma Yes / No _____

Sexual Abuse Yes / No _____

Emotional Abuse Yes / No _____

Physical Abuse Yes / No _____

Domestic Violence Yes / No _____

Obesity Yes / No _____

OCD Yes / No _____

Schizophrenia Yes / No _____

Other _____

List one positive quality of your mother:

_____

List one negative quality of your mother:

_____

List one positive quality of your father:

_____

List one negative quality of your father:

_____

How do/did your parents handle disagreement and conflicts with one another?:

_____

What is/was the main method of your parent's discipline with you and your siblings?:

_____

List your strengths.

_____

_____

_____

Is there a concern about violence in your life today (either from you or toward you)? Do you feel safe at home? Explain.

Are/were there major cultural or religious influences in your family? Describe.

Describe your family growing up.

Describe your childhood.

List areas you would like to develop or improve.

_____

_____

_____

Would you like anyone else involved in counseling with you? (family members, friends, etc.)

_____

_____

_____

What do you like most about yourself?

_____

_____

_____

What are some ways you cope with life obstacles and stress?

_____

_____

_____

What are your goals for therapy? What would you like to accomplish during your sessions?

_____

_____

_____

Is there anything else you would like to share?

_____

_____

_____

_____