Supplemental Intake Information
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CLIENT INFORMATION

Today's Date_____

Please print the following information:

Name _____
First Middle Last

What do you prefer I call you?_____

Preferred Personal Pronoun: (he/him, she/her, they/them, other) _____

Employer or School_____ Occupation or Major_____

How long have you worked/studied there?_____ How long in this occupation?_____

Education (list highest level of education attained)_____

How were you referred to me? _____

Orientation/Relationship status/Gender ID:

Partnered Status: (Married, Single, Partnered…) _____

Sexual Orientation: _____

Spouse/ Significant Other's Name_____

Names & Ages of Children_____

Please list everyone who shares your home_____

_____

MEDICAL INFORMATION

Name of your physician _____Date last seen _____

Please list any prescription and non-prescription medication you are currently taking.

Name of Drug	Dosage	Prescribed for	Approx for how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any significant medical problems_____

Frequency and amount of alcohol / recreational drug use:

_____

Amount of caffeine use_____

Quantity of cigarette smoking/nicotine use_____

Frequency and type of exercise _____

Amount of time in nature _____

Amount of sleep per night _____

PREVIOUS COUNSELING EXPERIENCE

Have you been in counseling before? Yes ____ No ____ If yes, please describe below:

1. Therapist's name _____Approx. duration & date last seen _____

2. Therapist's name _____Approx. duration & date last seen _____

Psychiatric hospitalizations? Yes ____ No _____ Dates _____

CURRENT REASON for SEEKING COUNSELING

Please describe briefly what has prompted you to seek counseling now, what changes you are hoping to make via counseling:

_____

_____

_____

Please check any of the following symptoms you have experienced in the past month:

__ Depression
__ Extreme sadness
__ Memory problems
__ Weight changes
__ Self-esteem problems
__ Perfectionism
__ Problems with anger
__ Feeling anxious
__ Feeling tearful
__ Physical pain
__ Thoughts of hurting yourself or others
__ Feeling hopeless
__ Trouble concentrating
__ Lack of energy
__ Feeling stressed
__ Easily irritated
__ Feeling guilty
__ Feeling fearful
__ Acting violently
__ Muscle tension
__ Feelings of panic
__ Thoughts of killing yourself or others
__ Obsessions or compulsions
__ Change in sleep habits
__ Change in eating habits
__ Feelings of extreme happiness
__ Change in sexual interest or function
__ Problems getting along w/ family
__ Trouble performing your job
__ Lack of enjoyment in usual activities
__ Impulsive behaviors
__ Poor judgment

Is there anything else you want me to know?_____

_____

_____