Intake Form
Dotti Caldwell, LPC

Contact Information

Name:

Birthdate: __/__/____ Phone Number: _____ C ○ H ○ W ○

Address: _____
_____

Email: _____

Do we have your permission to call / text you with appointment reminders?
☐ Yes ☐ No
Do we have your permission to email you with appointment reminders?
☐ Yes ☐ No

Emergency Contact and Number

Reason for Counseling

What is the main issue you would like to address in counseling?

How long has this issue been happening in your life?

Are any of these issues causing stress in your life?

- ❏ Family
- ❏ Friends
- ❏ Personal Relationship
- ❏ Education
- ❏ Economics / Financial
- ❏ Occupational / Work
- ❏ Housing
- ❏ Legal
- ❏ Health

Personal History

Mental Health History

1. Have you received counseling in the past? ☐ Yes ☐ No
   -If so when and for what reason?

2. Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No
   -If so when and for what reason?

3. Does your family have any history of diagnosed mental illnesses? ☐ Yes ☐ No

4. Have you ever been the victim of Physical, Sexual, Emotional, Verbal, or Financial abuse?
   ☐ Yes ☐ No

Medical History

1. Who is your primary care doctor? _____
2. When was your last physical?

3. Have you had any significant medical procedures (like surgery) or illnesses that you want your counselor to know about?
   ☐ Yes ☐ No
4. Please list any prescribed medication you are currently taking and their purpose.
   _____ for _____
   _____ for _____
   _____ for _____
   _____ for _____
   _____ for _____

Substance Use History

	None	Past	Present	Description & Frequency
Alcohol	☐	☐	☐	_____
Drugs	☐	☐	☐	_____
Nicotine	☐	☐	☐	_____
Caffeine	☐	☐	☐	_____

Have you ever received or been encouraged to receive treatment for any substance use issues?
☐ Yes ☐ No

Have you ever had and negative consequences resulting from substance use?
☐ Yes ☐ No

Have you ever attempted to harm or kill yourself?
☐ Yes ☐ No

Family and Social History

Does anyone in your family have a history of mental illness?
☐ Yes ☐ No
Were there any complications with your birth or your mother's pregnancy?
☐ Yes ☐ No
Did you have any delays or difficulties in school or childhood?
☐ Yes ☐ No

Marriage History

Are you currently married ☐ Yes ☐ No
Spouse's Name:
Do you have a girlfriend or boyfriend? ☐ Yes ☐ No
Partner's Name:
Have you ever been married before ☐ Yes ☐ No
How many times?
Have you ever been separated or divorced ☐ Yes ☐ No
How many times?
Have you ever been widowed? ☐ Yes ☐ No

Do you have any children? ☐ Yes ☐ No

What is your current family / living situation?

Outside of family, do you feel like you have a lot of friends?

Career/Educational History

Your current job or school setting:
Do you enjoy what you do most days?
☐ Yes ☐ No
What is your highest level of education?

How would you describe your relationship with your work or school colleagues?

Spirituality/Religious History

Do you adhere to any religion or belief system? ☐ Yes ☐ No
If so, what:

How important are those beliefs in your daily life?

What else provides significant meaning and fulfillment in your life?

Nutrition and Physical Activity

Do you generally eat a healthy diet? ◯ Yes ◯ No ◯ Varies

How many times per day do you consume the following

Substantial Protein (chicken/beef/etc):	1☐ 2☐ 3☐ 4☐ 5☐
Leafy Vegetables (spinach/broccoli/etc):	1☐ 2☐ 3☐ 4☐ 5☐
Starchy Vegetables (corn/potatoes/etc):	1☐ 2☐ 3☐ 4☐ 5 ☐
Ready Made/Processed food	1☐ 2☐ 3☐ 4☐ 5☐

Would you consider yourself: ◯ Underweight ◯ Normal weight ◯ Overweight ◯ Obese

How many bottles/full glasses of water do you drink per day? 1☐ 2☐ 3☐ 4☐ 5+☐

How many days per week are you physically active? 1☐ 2☐ 3☐ 4☐ 5+☐

Therapy Goals

What are your goals and dreams for the future?

What worries you about the fture?

What excites you about the future?

If our counseling journey is successful, what would be different in your life?