Alter Clinic

COUNSELING INTAKE FORM

Patient Name: Patient Name here

Date: Date here

Type of counseling I am seeking: Individual ☐ Couple ☐ Group Therapy ☐

PATIENT INFO

Date of Birth: _____ Legal Name: _____ Preferred Name:

Gender: _____ Preferred Gender Pronouns: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Preferred Phone #: _____

EMPLOYER & STATUS

Occupation: _____ Industry: _____ Company Name: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Employment Type: Employed ☐ Self-Employed ☐ Unemployed ☐ Other ☐

EMERGENCY CONTACT

Full Name: _____

Phone Number: _____

Relationship to you: _____

HEALTH AND MEDICAL INFO

Primary Care Physician: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Please list any medical problems: _____

Please list any current medications: _____

AVAILABILITY

Please check all that apply:

Time Available	MON	TUES	WED	THUR	FRI	SAT
8:00 AM						
9:00 AM						
10:00 AM						
11:00 AM						
12:00 PM						
1:00 PM						
2:00 PM						
3:00 PM						
4:00 PM						
5:00 PM						

PERSONAL & FAMILY

What is your ethnicity? _____

What is your marriage status? _____

How many people are in your household? _____

What is your income level? _____

What is the highest education level you've completed? _____

Have you ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Has a family member ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Does anyone in your family have a history of mental illness? Yes ☐ No ☐

Have you ever attempted suicide? Yes ☐ No ☐

Has anyone in your family attempted or committed suicide? Yes ☐ No ☐

Do you have substance abuse problems? Yes No

Does anyone in your family have substance abuse problems? Yes ☐ No ☐

Have you ever been arrested? Yes ☐ No ☐

If yes, please explain. _____

How well are you doing at your job? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing in your marital or with your significant other? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing with family relationships? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing in relationships with non-family members? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How is your current health? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How is your general happiness and well-being? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems