FLORIDA COUNSELING FOUNDATION
COUNSELING SERVICES

Roger Shepherd and Associates 407-831-2991

CONFIDENTIAL INTAKE FORM

GENERAL INFORMATION

Full name: ____ Date: _________________

Ethnicity: ❑ Asian ❑ Biracial/bicultural ❑ Black/African American ❑ Caucasian ❑ Hispanic/Latino
❑ Other

Sex: ❑ Male ❑ Female Date of birth: _____________________ Age: _________________

Address: ____

City: ____ State: ___________ Zip code: ___________

Cell phone: ____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No
Text Message OK? ❑ Yes ❑ No

Home Phone: ____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Work phone: ____ Call you here? ❑ Yes ❑ No
Message here? ❑ Yes ❑ No

Email: ____ Contact you here? ❑ Yes ❑ No

Employer: __________________________________ How long have you been there:_______________

Occupation: _________________________________ Average hours worked per week: _____________

Highest level of education completed: ___________ Are you currently in school? ❑ Yes ❑ No

If yes, what level? _______________________________ Degree pursuing: ____________________

In case of emergency, contact:

Name: ____ Relationship: ________________

Home phone: _________________________________ Cell phone: _____________________________

RELATIONAL INFORMATION

Relationship status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced
❑ Widowed ❑ Cohabitating and unmarried ❑ Partnered ❑ Unsure

How long have you been that status? ________________________________

Number of previous marriages for you? ____________ For your partner/spouse? ____________

Spouse's name: ________________________________ Spouse's age: __________

Is your spouse supportive of you seeking counseling? ❑ Yes ❑ No ❑ Unsure ❑ Spouse doesn't know

With whom do you currently live? (*Check all that apply*) ❑ Alone ❑ Spouse ❑ Children ❑ Parent(s) ❑Sibling(s) ❑ Boyfriend ❑ Girlfriend ❑ Roommate ❑ Other: _____________________________

List your children (including step, adopted, foster, deceased) below:

Name	**Sex**	**Age or year of death**	**Relationship to you**	**Living with whom?**

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _________________________________

Have you ever had a ❑ miscarriage or ❑ medical abortion? ❑ Yes ❑ No. If Yes, when ______________________

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	**Age or year of death**	**Relationship to you**	**Give 2-3 words to describe this person**

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue(s)	Dates/Number of Sessions

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries:

____

____

____

Your height: _______________ your weight: _______________

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _______lbs. ❑ down _______ lbs.

List all current medications you are taking, including those you seldom use or take only as needed:
(Use back if necessary)

Doctor & Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how: ____

Have any of your ❑ friends or ❑ family ever committed or attempted suicide? ❑ Yes ❑ No
If yes, when and who: ____

Are you presently experiencing any thoughts of harming yourself or another person? ❑Yes ❑No

PRESENT ISSUES
Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Past/Present		Past/Present		Past/Present	
❑ ❑	Stress	❑ ❑	Fears	❑ ❑	Controlled by others
❑ ❑	Anxiety or worry	❑ ❑	Shyness	❑ ❑	Obsessive thoughts
❑ ❑	Panic	❑ ❑	Low self-esteem	❑ ❑	Compulsive behaviors
❑ ❑	Depression	❑ ❑	Don't like myself	❑ ❑	Seeing things others don't see
❑ ❑	Crying all the time	❑ ❑	Marital problems	❑ ❑	Hearing voices
❑ ❑	Lack of motivation	❑ ❑	Other relational problems	❑ ❑	Racing thoughts
❑ ❑	Fatigue/Lack of energy	❑ ❑	Parenting problems	❑ ❑	Eating problems
❑ ❑	Poor appetite or overeating	❑ ❑	Physical abuse	❑ ❑	Drug use
❑ ❑	Trouble sleeping	❑ ❑	Emotional abuse	❑ ❑	Alcohol use
❑ ❑	Poor concentration	❑ ❑	Verbal abuse	❑ ❑	Pregnancy
❑ ❑	Feeling worthless or inferior	❑ ❑	Sexual abuse	❑ ❑	Abortion
❑ ❑	Feeling hopeless	❑ ❑	Sexual problems	❑ ❑	Legal matters
❑ ❑	Guilt	❑ ❑	Gender identity	❑ ❑	Work stress
❑ ❑	Death of friend or loved one	❑ ❑	Anger	❑ ❑	Career choices
❑ ❑	Grief	❑ ❑	Aggressive behavior	❑ ❑	Indecisiveness
❑ ❑	Chronic pain	❑ ❑	Bad dreams	❑ ❑	Lack of discipline
❑ ❑	Physical disability	❑ ❑	Unwanted memories	❑ ❑	Financial problems
❑ ❑	Terminal illness	❑ ❑	Loss of control	❑ ❑	Spiritual apathy
❑ ❑	Health concerns	❑ ❑	Impulsive behavior	❑ ❑	Other__________
❑ ❑	Loneliness	❑ ❑	Controlling	❑ ❑	

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

|——————————————————————————————————|

Minimally Distressing | Moderately Distressing | Extremely Distressing

Please describe why you are coming to counseling *(i.e., what are your issues, problems?)*:

____
____
____

Why have you decided to come for counseling now?

____
____
____

What do you hope to gain or change by coming for counseling?

____
____
____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. <u>I further understand that without 24-hour notice of intention to cancel,</u> <u>I will be charged the full administrative fee for service.</u>

Signed: ____ Date: ____________________