FOX BEND COUNSELING

For Office Use Only:
Therapist: _____
Dx: _____._____

CLIENT INTAKE INFORMATION

Client Name: _____
Last First MI

Date of Birth: _____ *Social Security Number _____

Address: _____

May we send correspondence to this address? No Yes

If no, please list an alternate address _____

Home Phone: _____ May we leave a message? _____

Cell Phone: _____ May we leave a message? _____

Business Phone: _____ May we leave a message? _____

Email: _____ May we send emails? No Yes

How were you referred to us? (Please Circle)

Google Psychology Today Good Therapy

Therapist's Personal Website: Stephanie Christy Teresa

Fox Bend Counseling Website

Other: _____

If you were referred by someone would you allow us to send them a thank you note? No Yes

If yes, please share their name and address if you know it:

_____

FOX BEND
COUNSELING

PERSONAL INFORMATION

Place of Employment: _____

Job Title: _____ Time at current job: _____

Highest education completed: High School/GED Some College College Graduate/Other

Marital Status: Single Married Divorced Widowed Other

If you have children, please list their names and ages:

Name: _____ Age: ____ Name: _____ Age: ____

Name: _____ Age: ____ Name: _____ Age: ____

Church of religious affiliation: _____

Have you ever been in counseling before? No Yes

If yes, what for: _____

Have you ever been given a mental health diagnosis? No Yes

If yes, what diagnosis: _____

Has anyone in your family been diagnosed with a mental health disorder? No Yes

If yes, what diagnosis: _____

Are you currently taking any medications? No Yes

If yes, please list:

_____

_____

What is your main reason for seeking out therapy at this time?

_____

_____

Who is your primary care physician? _____ Phone:_____

In case of an emergency, whom should we notify?

_____ Phone: _____

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Please select any of the following that you may be currently experiencing:

- Always tired
- Can't sleep
- Full of energy
- Crying spells
- Easily annoyed
- Can't concentrate
- No motivation
- Feeling panicked
- Nightmares
- Unable to relax
- Overly sensitive
- Panic/Anxiety attacks
- Quick tempered
- Impatient
- Restless
- Suicidal thoughts
- Cutting
- Feeling tense
- Stomach issues
- Diarrhea/constipation
- Nausea/Vomiting
- Headaches
- Migraines
- Fast heartbeat
- Frequent Sweating
- Dizziness
- Fainting
- Loss of weight
- Weight gain
- Chronic Illness
- Financial problems
- Marital problems
- Issues with your children
- Issues with your parents
- Difficulties at work
- Difficulties at school
- Confused about spiritual life
- Feeling lonely
- Depressed
- Feeling unable to connect
- Can't have fun/laugh
- Recent loss of someone
- Too sensitive
- Afraid to be alone
- Worries about health
- No one understands me
- Can't forgive someone
- Can't forgive myself
- Sexual difficulties
- Unable to make decisions
- Overwhelmed
- Feel like hurting someone
- I'm too shy
- I can't make friends