Whipple Counseling

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Intake Form

Date ___________ Last Name _________________________________ First Name _________________________________

Address ____ City ___________________ State ______ Zip ______________

Do I have permission to mail to this address? Y / N

Email Address ____ Do I have permission to email you? Y / N

Home Phone ____ Work Phone ____

Sex (M/F) ______________________ DOB ___________________

Is it acceptable to contact you at home? Y / N If "no" then how can I contact you?_________________________________

Are you currently under medical care? Y / N If yes, then please explain/describe. ________________________________

Name of Primary Physician ____Phone Number ___________________________

Are you currently taking prescribed medications? Y / N
If yes, then please explain/describe. ____

List any psychiatric/mental health medications you have taken:____

____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem.

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How were you referred to my office?____

Who may I thank for referring you to my office?____

Emergency Contact/Relation:____ Phone:___________________________

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders	Sexual Problems
Suicidal Thoughts	Separation/Divorce	Relationships	Finances	Drug/Alcohol Use
Career Choices	Anger	Self-Control	Unhappiness	Insomnia
Religious Matters	Work/Stress	Health Problems	Cutting/Self-Mutilation	Thought Patterns

____ ________________

Client Signature **Date**