ENCOURAGE counseling

Safe Space…Deep Healing

1189 South Perry Street, Suite 140, Castle Rock, Colorado, 80104 * 720-230-3076

Adult Counseling Intake Form

Note: This information may be confidential; however certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better enCOURAGE Counseling, LLC is able to meet your specific needs.

Demographic Information:

Name: _____ Date: _____

Date of Birth (DOB): _____ Gender: _____

Age: ____ **Relationship Status:** *Single Married Divorced Separated Widowed Other:* ____

Mobile Phone: _____ *Is it okay to leave a message for you at this number?* ***Y or N***

Home Phone: _____ *Is it okay to leave a message for you at this number?* ***Y or N***

Work Phone: _____ *Is it okay to leave a message for you at this number?* ***Y or N***

Email: _____ *Is it okay to email you?* ***Y or N***

Mailing Address: _____

Current Employer: _____

Is your primary insurance Medicaid? ***Y or N***

Emergency Contact: _____ Phone Number:_____

Relationship: _____ Who referred you?: _____

Preferred mode of communication: ☐ email or ☐ phone (voice) or ☐ phone (text)

*Please review the enCOURAGE Counseling's HIPAA and Notice of Privacy Policies and Consent for Communication by Non-Secure Transmissions before agreeing to receive communication via electronic means.

Current Concerns:

Please describe why you are seeking counseling and any issues/problems that led you to seek counseling.

In the past, what has been helpful for you in dealing with this problem?

What part does faith, religion, and/or spirituality play in your life?

Do you attend a place of worship? ☐ YES ☐ NO Name of church: _____

Do you want to integrate your faith into the counseling experience? ☐ YES ☐ NO

Among your friends and family, on whom do you count for support (spiritual, emotional, financial, etc.)?

Do you smoke?

Tobacco: ☐ YES ☐ NO At what age did you start? _____

Marijuana: ☐ YES ☐ NO At what age did you start? _____

Do you use drugs? ☐ YES ☐ NO At what age did you start? _____

Drug(s) of choice? _____

Do you drink alcohol? ☐ YES ☐ NO How many drinks per week? _____

Do you have other addictions (e.g. sex, gambling, etc.)? ☐ YES ☐ NO

Danger to Self or Others:

Have you ever had thoughts of harming yourself or others? ☐ YES ☐ NO

If yes, please explain:

_____

_____

Have you ever seriously considered suicide or attempted suicide? ☐ YES ☐ NO

If yes, please explain:

_____

_____

Do you have the intent and means to commit suicide right now?

_____

_____

Medical and Mental Health History:

Are you experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc.?
If yes, please explain:

_____

_____

Are there any significant past or present **health or medical** issues that I should be aware of?

_____

_____

Are there any significant past or present **mental health** issues that I should be aware of?

_____

_____

_____

Medications

If applicable, please list all the medications you are now taking and/or have taken in the past three months:

Medication:	***Dosage:***	***Prescriber:***	***How long have you been taking this?***	***Helpful? (Y/N)***

Name and phone number of physician*: _____

Name and phone number of psychiatrist* (if any): _____

Name and phone number of current or previous counselor* (if any): _____

_____

*Please note: In accordance with applicable HIPAA and Colorado regulations, I will not contact your physician, psychiatrist, or counselor without your knowledge and consent.

Have you ever experienced abuse (emotional, physical, and/or sexual)? ☐ YES ☐ NO
If yes, please describe (including dates and relationship to the abuser).

_____

_____

_____

Have you ever experienced other types of trauma? ☐ YES ☐ NO
If yes, please describe (including dates and event).

_____

_____

Have you ever experienced flashbacks concerning the abuse? ☐ YES ☐ NO
If yes, how often?

_____

_____

Family of Origin Information:

Describe your immediate family (e.g. parents, siblings, ages, etc.):

_____

_____

_____

Does your family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? ☐ YES ☐ NO
If yes, please explain:

_____

_____

Relationship Status

Describe your relationship with your current partner. Please include how long you have been together and/or married:

_____

_____

What are the strengths of your relationship?

_____

_____

What are the weaknesses of your relationship?

_____

_____

What do you like most about your partner?

_____

_____

What do you dislike about your partner or have a hard time tolerating?

_____

_____

Has there been any domestic violence in your relationship?

_____

_____

Children (Include biological, step, adopted, & foster).

Name:	***Age:***	***Gender:***	***Living with you?***

Sentence Completion:

Please complete the following sentences:

I came here today _____

My relationship is _____

I am really happy when _____

I feel mad when _____

Growing up in my family _____

If I could change one thing _____

Six months from now _____

Is there anything else I need to know to better assist you?

_____

_____

_____

Signatures:

_____ _____
Client (please print) Date

_____ _____
Client (signature) Date

_____ _____
Counselor (signature) Date