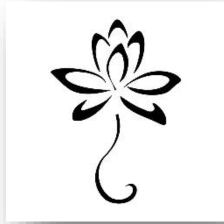

A Caring Counselor
9900 W. Sample Rd. Suite #300
Coral Springs, Florida 33065
(954) 793-6442
acaringcounselor.com

I N T A K E F O R M

Please provide the following information and answer the questions below.

Please note: information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): ____________________________
(Last) (First)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age: ____

____

____

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ____

May we leave a message? □ Yes □ No

Cell/Other Phone: ____

May we leave a message? □ Yes □ No

E-mail: ____

May we email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

Previous therapist/practitioner: ____

Are you currently taking any prescription medication? □ Yes □ No

Please list:

____

____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

____

3. How many times per week do you generally exercise? ______________________

What types of exercise to you participate in?________________________________

____

4. Please list any difficulties you experience with your appetite or eating patterns:

____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes

If yes, for approximately how long? ______________________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □ Yes

If yes, when did you begin experiencing this? ______________________________

7. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe: ____

8. Do you drink alcohol more than once a week?
□ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly

□ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship? __________

11. What significant life changes or stressful events have you recently experienced?

____

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify (please indicate by circling) if there is a family history of any of the following:

Alcohol/Substance Abuse	Anxiety	Depression
Domestic Violence	Eating Disorders	Obesity
Obsessive Compulsive	Schizophrenia	Suicide Attempts

If yes, please indicate in the space below, family member relationship (ex. Dad was abusive, mom alcoholic) and if they sought treatment for this issue.

____

____

____

____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?