Intake Form (Adult)

Hope Springs Counseling

Name: _____ Date**:**_____ **Age**:_____

Date of Birth: _____

Home Phone: _____
Is it okay to leave a voicemail message at this number? ____ yes ____no
Cell Phone: _____
Is it okay to leave a voicemail message at this number? ____ yes ____ no
Is it okay to text you at this number? ____ yes ____ no

I give my permission for Lisa Bizon/Hope Springs Counseling as well as authorized agents to bill my insurance and to include any relevant HIPPA-protected information that may be relevant and necessary to do so. ___ yes ____ no

Address: _____

_____

Email: _____

Emergency Contact: _____

Emergency Contact Phone: _____

<u>Presenting Issues and Concerns</u>

Please describe the problem that brings you into counseling, when these issue began, and the length of time you have experienced them: _____
_____
_____
_____
_____

Counseling mental health history_____
_____

Health/Medication:
_____
_____

Sleep: _____

Nutrition: _____

Exercise: _____

Fun/Relaxation/Hobbies: _____

_____

Spirituality/Religious Beliefs (if any): _____

_____

Education: _____

Work/Occupation: _____

Have you served in the military? _____

If so, did you deploy? _____ How many times and to where? _____

_____

Have you ever sustained a brain injury? If yes, how many times and to what degree of severity?

_____

Stress level at work (high/medium/low): _____

Living environment/Other members of household: _____

_____

Personal support system: _____

Please briefly describe your childhood: _____

_____

_____

Where were you raised? _____

Did your family move? ___ If so, how often and at what age(s)? _____

Father_____ Age____ Occupation when you were growing up: _____

Mother_____ Age____ Occupation when you were growing up: _____

Other significant adults in your life growing up: _____

Childhood abuse and/or neglect: _____

_____

Siblings/Ages: _____

Significant life events both positive and negative: _____

_____

Primary relationship (marriage or significant other): _____

Relationship history: _____
_____
_____

Self-defeating behaviors:
_____
_____
_____

Drug and alcohol history: _____
_____
_____

Suicide attempts: _____

Victim or perpetrator of violence? _____

Felony Record? _____

What other information do you believe is important for me to know in order to be able to help you most effectively? _____
_____
_____

What specific goals do you have for therapy? _____
_____
_____
_____

Check all of the issues/symptoms below that you are experiencing, and please estimate the length of time you have experienced them:

___ Anxiety/Chronic Worry _____
___ Panic attacks _____
___ Lack of interest in usual activities _____
___ Loss of pleasure _____
___ Fatigue/tiredness _____
___ Sadness/depression _____
___ Thoughts of suicide _____
___ Homicidal thoughts _____
___ Loss of concentration/confusion _____
___ Aggressive behaviors _____
___ Frequent boredom _____
___ Fear of leaving home _____
___ Irritability/anger _____
___ Need to be alone/ or withdraw _____
___ Social fear/discomfort _____
___ Paranoia/ excessive suspicion _____
___ Recurrent troubling thoughts _____
___ Flashbacks/Recurring memories _____
___ Hearing voices _____
___ Visual hallucinations _____
___ Obsessive thoughts _____
___ Excessive energy _____

___ Loneliness _____
___ Seasonal mood changes _____
___ Feelings of low self-worth/esteem _____
___ Feelings of guilt/shame _____
___ Feelings of hopelessness _____
___ Sleep disturbances_____
___ Nightmares_____
___ Frequent bouts of crying _____
___ Racing thoughts _____
___ Thoughts of/fear of death _____
___ School-related problems _____
___ Parenting Problems _____
___ Mood Swings _____
___ Compulsive behaviors _____
___ Frequent arguing with others _____
___ Appetite problems _____
___ Eating problems _____
___ Work-related problems _____
___ Gambling problems _____
___ Sexual problems _____
___ Alcohol/drug use _____
___ Computer-related addiction _____
___ Problem with pornography _____
___ Self-harming behaviors _____

Which areas of your life are being affected by the above (checked) problems:

___ Ability to cope with everyday activities
___ Sexual functioning
___ Fun/recreation/hobbies
___ Health issues
___ Relationships
___ Work/school
___ Living situation
___ Finances
___ Legal issues
___ Personal hygiene
___ Housing

Clinician Notes:

_____
_____
_____
_____

_____ _____
Client Name: (Please Print) **Date:**

_____ _____
Client Signature: **Date:**

_____ _____
Client Name: (Please Print) **Date:**

_____ _____
Client Signature: **Date:**

_____ _____
Lisa M. Bizon, M.S., N.C.C., LPC: **Date:**