

MKL COUNSELING: CONFIDENTIAL INTAKE FORM

Please answer the following questions honestly and to the best of your ability.

Name: _____ **Date:** _____

Date of Birth: ____/____/____ Age: ____ Gender: F M

Street Address: _____

City: _____ Zip: _____ County: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Policy Holder _____ Insurance Company _____ DOB _____

SS# _____ ID# _____ Grp# _____ Deductable/Co pay _____

Emergency Contacts

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Employment

Current Employer: _____ Job Title: _____

Work Phone: _____ Length of time at current job: _____

Family

Relationship Status (*circle all that apply*):

Single Partner Married Separated Divorced Widowed Remarried

Biological Children (include age and gender): _____

How Did You Hear about Us: Google__ Facebook__ Friend__ Other_____

Other

Highest Educational Level: _____

If College Graduate, Degree and Major: _____

Hobbies/Interests: _____

Have you ever served in the Military? No Yes

If Yes: Branch: _____ When: _____

Have you ever been convicted of a crime? No Yes-Explain: _____

Are you on Probation? Parole? Probation/Parole Officer: _____

Smoker: No Yes-How much per day? _____ For how long? _____

Drinker: No Yes-How much per day? _____ Age of first drink: _____

Exercise: Never 1-2 times/week 3-4 times/week 5-7 times/week

Overall Diet: Very Healthy Moderately Healthy Unhealthy Very Unhealthy

Religion: _____ Involved in church? No Yes

Describe church involvement: _____

MEDICAL HISTORY

Current Medication(s)	Dosage	Frequency	Prescribed by

Any Unwanted Side Effects? No Yes-Describe: _____

Psychotropic Medications Previously Prescribed: _____

PCP: _____ Psychiatrist: _____

Last Physical Exam: _____ Results: _____

Your Current Physical Health: Poor Unsatisfactory Satisfactory Good Excellent

Recent Hospitalizations: _____

Recent Surgeries: _____

Recent Accident/Injuries: _____

Current Medical Problems or Persistent Physical Symptoms (*chronic pain, headaches, hypertension, diabetes, etc*): _____

FAMILY HISTORY

1. Is your mother still alive? Yes No-When: _____ Age at death: _____

2. Is your father still alive? Yes No-When: _____ Age at death: _____

3. Did you parents divorce? No Yes-How old were you? _____

4. Mother's Occupation: _____

5. Father's Occupation: _____

6. Were you adopted? No Yes-How old were you? _____

7. Has anyone in your family attempted or committed suicide? No Yes

If yes, who and method: _____

8. Family Members with Mental Health Conditions

Relationship	Disorder	Medications	Ever hospitalized?	Currently in Treatment?

9. Are you experiencing any family difficulties? Yes No

If yes, please describe: _____

_____ Are any family members a source of emotional support for you? Yes No

MENTAL HEALTH HISTORY

1. Previous counseling? Yes No
If yes: when, duration, and why? _____

2. Are you currently feeling suicidal? Yes No
3. Have you ever felt suicidal? No Yes-When: _____
4. Have you ever attempted suicide? No Yes
If yes, when and method: _____
5. Do you feel violent toward anyone? No Yes
If yes, explain: _____
6. Have you been violent in the past? No Yes
If yes, explain: _____
7. Violent Family Members: _____
8. Do you struggle with substance abuse? No Yes
If yes, please specify: _____
9. Do you have family members who abuse substances? No Yes
If yes, specify who and substance: _____

10. Have you experienced any significant changes in your life recently? No Yes
If yes, please explain: _____

11. Has anyone close to you died recently, including a pet? No Yes
If yes, please state who and relationship: _____

12. Check any abuse you experienced as a child: Physical Sexual Emotional/Verbal
13. Have you ever been raped or sexually traumatized? No Yes-When: _____
14. Have you experienced any other traumatizing events? No Yes
If yes, please explain: _____

RELATIONSHIP HISTORY

1. Have you recently ended a relationship? No Yes
If yes, when and how long did it last? _____
2. If in a partnership or marriage, how long? _____
How satisfied are you in your relationship?
(*Very Dissatisfied*) 1-----2-----3-----4-----5 (*Very Satisfied*)
3. Are you experiencing any sexual difficulties? No Yes
If yes, please explain: _____
4. Describe any areas of conflict with your partner: _____

5. How many close friendships do you have? None 1-2 3+
6. Do you turn to your friends when you need help or support? No Yes

PRESENTING CONCERNS / COUNSELING GOALS

1. What concerns have caused you to seek counseling at this time?

- Personal Mental Health Concerns
- Family Concerns
- Intimate Relationship Concerns
- Financial Concerns
- Career/School Concerns
- Medical or Health Concerns
- Legal Concerns
- Parenting Concerns
- Sexual Concerns
- Identity Concerns
- Alcohol or Drug Concerns
- Interpersonal Concerns
- Grief/Loss/Death
- Other: _____

2. How much distress have you been experiencing from the above concern(s)?

(mild) 1-----2-----3-----4-----5 (severe)

3. How long have you been feeling this way? _____

4. Did anything ***that you're aware of*** precipitate your present concerns? No Yes

If yes, please describe: _____

5. What are your goals for counseling? _____

6. How long do you expect counseling to last? _____

7. What is currently causing you stress in your life? _____

8. Any other information that might be helpful that I haven't asked? _____

Important Information: Your Counselor is a mandated by law to report if you are in imminent danger to yourself or to others (No exceptions). All sessions are confidential and only by your written consent, then and only then pertinent information can be revealed to outside institutions. The Counselor can verbally terminate sessions at any time and any remaining monies will be refunded to the counselee within seven days. Most communications will be by phone or text which might not be HIPPA compliant (most secure). Please express another form of communication before signing. If using your Insurance you may be charged up to \$140 a session which may differ from selfpay rate. You are 100% responsible for all monies due if your insurance does not pay for any reason. Before signing this agreement be familiar with the information on the mklcounseling.com website and fully understand the payment and cancelation terms.

I _____ have answered these questions truthfully and I completely understand termination, payment, cancelation and confidentiality terms of MKL Counseling.

Sign _____ Date _____