MAKARIOS COUNSELING

CONFIDENTIAL INTAKE FORM

PERSONAL INFORMATION

Date: ______________________ Referred by: _____________________________________

Full name: __________________________________ Name you prefer: __________________

Date of birth: ____________ Age: ____ Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other ____________________

Street Address: ____ Suite/Apartment #: _______________

City: ________________________ State: ____________ Zip Code: ______________ Home Phone: _________________

Cell Phone: ____________________________ Email: ____

May we contact you at the numbers/email above? ☐ Yes ☐ No

Employer: _______________________________________ How long have you been there: ________________________

Occupation: ______________________________________ Average hours worked per week: _______________________

Highest level of education completed: ____________________ Are you currently in school? ☐ Yes ☐ No

If yes, what level? __________________________________ Degree pursuing: _________________________________

SPIRITUAL HISTORY

Do you regularly attend a place of worship: ☐ Yes ☐ No If yes, where? _______________________________________

What is the name of your pastor, priest, rabbi, or other spiritual leader? ____

What words would you use to describe yourself? ____

If God were to describe you, what would He say? ____

Briefly describe the religious environment of your home as you were growing up: ____________________________________

____

Complete the following thought: God is ____

Do you have a personal support system (who do you contact with good/bad news): ☐ Yes ☐ No If yes, who/where?

____

COUNSELING HISTORY

Facility/Program/Physician/Therapist:	Dates of Services:	Reason for Treatment/Interventions:

Did you find counseling to be helpful? ☐Yes ☐No. Please explain:

____

____

MAKARIOS COUNSELING

RELATIONAL INFORMATION

Current Marital Status: ☐Single ☐Dating ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed

How long has this been your status? ____

Number of previous marriages? ________________________ For your partner/spouse? ______________________

Partner/Spouse's name: ______________________________ Partner/Spouse's age: ____________

Is your partner/spouse supportive of you seeking counseling? ☐Yes ☐No ☐Unsure ☐He/She doesn't know

With whom do you currently live: (*Check all that apply*)

☐Alone ☐Spouse ☐Children ☐Parent(s) ☐Sibling(s) ☐Boyfriend ☐Girlfriend ☐Roommate ☐Other_____________

Family Members *(Indicate if biological or custodial family)*

Name	Age	Relationship	Give 2-3 words to describe this person and the positive/negative impact this person made on your life.
Family Issues/Problems:			

Have you ever placed a child for adoption: ☐Yes ☐No. If yes, when? ____

Have you ever had a miscarriage: ☐Yes ☐No. If yes, when?

____

Have you ever had a medical abortion: ☐Yes ☐No. If yes, when?

____

MEDICAL HISTORY

List any medical conditions, illnesses, treatments, or surgeries *(Use back of page if necessary)*: ________________________

____

Has your weight changed in the last 2-3 months: ☐little to no change ☐up ______ lbs. ☐Down ______ lbs.

List all current medications you're taking including those you seldom use or take only as needed. *(Use back of page if necessary)*:

Current Medication	Dosage/Frequency:	Reason for taking medication

MAKARIOS COUNSELING

Have you ever had or currently have any of the following ***(Check boxes. If yes, indicate year of first occurrence)*****:**

Issue	Current/Past	Year	Issue	Current/Past	Year
High Blood Pressure	☐ ☐		Dizziness/fainting	☐ ☐	
Heart Problems	☐ ☐		Head Injury	☐ ☐	
Respiratory Problems	☐ ☐		Ulcers	☐ ☐	
Asthma	☐ ☐		Intestinal Problems	☐ ☐	
Cancer	☐ ☐		Hepatitis	☐ ☐	
Thyroid Problems	☐ ☐		Abdominal Problems	☐ ☐	
Diabetes	☐ ☐		Anemia/sickle cell	☐ ☐	
Anorexia	☐ ☐		Sinus Problems	☐ ☐	
Bulimia	☐ ☐		Arthritis	☐ ☐	
Other eating disorder	☐ ☐		Seizure disorder	☐ ☐	
Frequent or severe headaches	☐ ☐		Sexually transmitted disease(s)	☐ ☐	

Are you presently experiencing any suicidal thoughts? ☐Yes ☐No. Have you experienced suicidal thoughts in the past? ☐Yes ☐ No

Have you ever attempted suicide? ☐Yes ☐No. If yes, when and how: ____

____

Have any of your friends or family ever committed or attempted suicide? ☐Yes ☐No. If yes, who, when, and how: ____________

____

Are you presently experiencing any thoughts of harming another person? ☐Yes ☐No

Substance Use Information

Substance	Current/Past	Age of first use	Amount Used	Frequency of use	Date of last use
Tobacco	☐ ☐				
Alcohol	☐ ☐				
Cannabis	☐ ☐				
Hallucinogens	☐ ☐				
Cocaine	☐ ☐				
Stimulants	☐ ☐				
Narcotics	☐ ☐				
Inhalants	☐ ☐				
Prescriptions	☐ ☐				
Other Substances:					
Comments:					
AA: ☐Yes ☐No. **NA:** ☐Yes ☐No. **Other**: ☐Yes ☐No. If yes, what program?				Current Length of Sobriety:	

MAKARIOS COUNSELING

PRESENTING CONCERNS:

Issue	Current/Past	Issue	Current/Past	Issue	Current/Past
Stress	☐ ☐	Hearing voices	☐ ☐	Controlling	☐ ☐
Anxiety or Worry	☐ ☐	Chronic Pain	☐ ☐	Controlled by others	☐ ☐
Panic	☐ ☐	Physical disability	☐ ☐	Impulsive behavior	☐ ☐
Depression	☐ ☐	Terminal Illness	☐ ☐	Guilt	☐ ☐
Crying all the time	☐ ☐	Health Concerns	☐ ☐	Racing thoughts	☐ ☐
Lack of motivation	☐ ☐	Loneliness	☐ ☐	Eating problems	☐ ☐
Fatigue/lack of energy	☐ ☐	Fear(s)	☐ ☐	Drug use	☐ ☐
Trouble sleeping	☐ ☐	Shyness	☐ ☐	Alcohol use	☐ ☐
Poor concentration	☐ ☐	Anger	☐ ☐	Pregnancy	☐ ☐
Feeling worthless/inferior	☐ ☐	Aggressive behavior	☐ ☐	Abortion	☐ ☐
Feeling hopeless	☐ ☐	Physical Abuse	☐ ☐	Legal matters	☐ ☐
Low self-esteem	☐ ☐	Emotional Abuse	☐ ☐	Work stress	☐ ☐
Don't like myself	☐ ☐	Sexual Abuse	☐ ☐	Career choices	☐ ☐
Marital Problems	☐ ☐	Gender Identity Issues	☐ ☐	Indecisiveness	☐ ☐
Other relational problems	☐ ☐	Bad Dreams	☐ ☐	Lack of discipline	☐ ☐
Parenting problems	☐ ☐	Unwanted memories	☐ ☐	Financial problems	☐ ☐
Death of friend/loved one	☐ ☐	Loss of control	☐ ☐	Spiritual apathy	☐ ☐
Seeing things others don't see	☐ ☐	Compulsive behaviors	☐ ☐	Grief	☐ ☐
Extramarital affair	☐ ☐	Pornography use	☐ ☐		

Other: ____

When did this issue/problem first begin? ____

How long have you dealt with this issue/problem? ____

How often do you experience this issue/problem? ____

Please indicate level of distress associated with the problem(s) you are experiencing:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Low **High**

Please describe why you are coming to counseling *(any issues, problems)*: ____

____

Please state the reason you have decided to come for counseling at this point in time: ____

____

What do you hope to gain or change by coming for counseling? ____

____

EMERGENCY CONTACT:

Name: ______________________ Relationship: ______________________ Cell Phone: ______________________

By signing this document, I acknowledge I am giving permission for the person listed immediately above to be contacted in case of an emergency.

TERMS OF SERVICE:

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I may be charged the full fee for service.

Client signature: ______________________ Date: ______________________