Pryor & Associates Counseling and Diagnostic Center

Counseling-Therapy Intake Form

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DESOTO, TEXAS 75115

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COUNSELING-THERAPY INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

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

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

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: _____________ Gender: ________________

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. 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 experienced recently:

   ____

12. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
13. 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? __________

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

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Problem	YES OR NO (Please Circle)	List Family Member
Alcohol/Substance Abuse	YES / NO	
Anxiety	YES / NO	
Depression	YES / NO	
Domestic Violence	YES / NO	
Eating Disorders	YES / NO	
Obesity	YES / NO	
Obsessive Compulsive Behavior	YES / NO	
Schizophrenia	YES / NO	
Suicide Attempts	YES / NO	

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 weakness?
____
____
____
____

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