Woodforest Counseling

LIVE. LOVE. THRIVE.

INTAKE INFORMATION FORM

We are honored that you have chosen Woodforest Counseling to provide counseling services. We hope to do our best to assist you in making your counseling experience the best it can possibly be! Please fill out the pages below and let us know if you have any questions.

INTAKE INFORMATION FORM

Client Name: _____ Date: _____

Gender: ☐ Female ☐ Male Date of Birth: _____ Age: _____

Form completed by (if someone other than client): _____

Primary reason(s) for seeking services (Please check the following that applies):

☐ Marital Problems
☐ Parenting
☐ Relationship
☐ Family
☐ Anger Management
☐ Anxiety
☐ Coping
☐ Depression
☐ Eating Disorder
☐ Fear/Phobias
☐ Mental Confusion
☐ Sexual Concerns
☐ Sleeping Problems
☐ Addictive Behaviors
☐ Alcohol/Drugs
☐ Eating Habits
☐ Job
☐ Medical/Health Problems
☐ Other (Please Describe:)
_____

Marital Status: (More than one answer may apply):

☐ Single
☐ Legally Married
☐ Widowed
☐ Divorce in Process
☐ Separated
☐ Annulment
☐ Unmarried/Living Together
☐ Divorced
Total Number of Marriages: _____

Legal:

Are you involved in any criminal proceedings or litigation at the present time? ☐ Yes ☐ No

If yes, describe:

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, describe:

Education:

Level of education completed:

☐ GED	☐ Associates	☐ Doctorate
☐ High School	☐ Bachelor's	☐ Other:
☐ Some College	☐ Master's	_____

Currently enrolled in school? ☐ Yes ☐ No

If yes, where:

Special circumstances (e.g., learning disabilities, gifted):

Military:

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Where:

Branch: Discharge Date:

Type of Discharge:

Family Information:

Relationship	Name	Age	Living	Living with you
Mother	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Father	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Spouse	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child (1)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child (2)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child (3)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Child (4)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Significant Others: Please list

Relationship	Name	Age	Living	Living with you
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Medical/Physical Health: (Please check the following that applies):

☐ AIDS	☐ Drug Abuse	☐ Anemia
☐ Alcoholism	☐ Epilepsy	☐ Neurological Disorder
☐ Abortion	☐ Eating Problems	☐ Sexual Problems
☐ Bladder Control	☐ Fatigue	☐ Sleeping Disorder
☐ Cancer	☐ Hepatitis	☐ Stomach aches/vomiting
☐ Chronic Pain	☐ Headaches/Migraines	☐ STD's
☐ Dizziness	☐ High Blood Pressure	☐ Thyroid PRoblems
☐ Diabetes	☐ Mononucleosis	☐ Covid side effects

Other (describe):

List any current health concerns:

List any recent health or physical changes:

Current Prescribed Medications	Dose	Length of Time	Purpose	Side Effects

Current Prescribed Medications:

Current Over-the Counter Medications	Dose	Length of Time	Purpose	Side Effects

Family history of medical problems:

Please check if there have been any recent changes in the following:

- ☐ Sleep Patterns
- ☐ Eating Patterns
- ☐ Behavior
- ☐ Physical Activity Level
- ☐ Weight
- ☐ General Disposition
- ☐ Nervousness/Tension
- ☐ Energy Level

Describe changes in areas in which you checked above:

Please tell us about your prior counseling and/or treatment history:

Family Information	Yes	No	When	Where
Counseling/ Psychiatric Treatment	☐	☐	_____	_____
Reason/Diagnosis	_____			
Counseling/ Psychiatric Treatment	☐	☐	_____	_____
Reason/Diagnosis	_____			
Counseling/ Psychiatric Treatment	☐	☐	_____	_____
Reason/Diagnosis	_____			

Counseling/ Psychiatric Treatment	☐	☐	_____	_____
Reason/Diagnosis	_____			
Counseling/ Psychiatric Treatment	☐	☐	_____	_____
Reason/Diagnosis	_____			

Have any of your family members or significant others had counseling or treatment in any of the below areas?

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often and in what quantity:

Have you used/abused drugs, alcohol or controlled substances? ☐ Yes ☐ No

If yes, please explain:

Does/has someone in your family have/had a problem with drugs or alcohol? ☐ Yes ☐ No

If yes, please describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ☐ Yes ☐ No

If yes, please describe:

Have drugs or alcohol created a problem for your job/relationship? ☐ Yes ☐ No

If yes, please describe:

Suicidal Thoughts/ Attempts ☐ Yes ☐ No

Involvement with Self-help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)

Behavioral History:

Please check behaviors and symptoms that are problematic for you:

- ☐ Aggression
- ☐ Alcohol Dependence
- ☐ Anger
- ☐ Anemia
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Avoiding People
- ☐ Chest Pain
- ☐ Cyber Addition
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug Dependence
- ☐ Eating Disorder
- ☐ Phobia/Fear
- ☐ Fatigue
- ☐ Gambling
- ☐ Sexual Addiction
- ☐ Heart Palpitations
- ☐ High Blood Pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgment errors
- ☐ Loneliness
- ☐ Memory Impairment
- ☐ Mood Shifts
- ☐ Hyperactivity
- ☐ Panic Attacks
- ☐ Pornography
- ☐ Disruptive Thoughts
- ☐ Spending Problems
- ☐ Sexual Difficulties
- ☐ Sleeping Problems
- ☐ Suicidal Thoughts
- ☐ Disorganized Thoughts
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Social Problems
- ☐ Other (please list)

_____

Briefly discuss how the above symptoms impact your ability to function:

Does anyone in your family have a history of anxiety, depression, or other mental health problems?

☐ Yes ☐ No

If yes, please describe:

Stress Indicators:

Were there special, unusual, or traumatic circumstances that affected you in childhood? (i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)

☐ Yes ☐ No

If yes, please describe:

Please check any events that have occurred in the last 12 months:

☐ Moving ☐ Job Change ☐ Pandemic Diffculty

☐ Marriage ☐ Financial Problems ☐ Death of friend/family

☐ Natural Disaster ☐ Birth of Child

COUNSELING GOALS

What would you like to see accomplished in your counseling?

1.

2.

3.

4.