SOLAY Counseling & Research Center, PC

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Client Intake Information

Today's Date: _____

Client Name: _____
(First) *(Middle Initial)* *(Last name)*

DOB: _____/_____/_____ AGE: _____ SS or ID #: _____

Race: _____

Gender Identity:
Male/Man ___ Female/Woman ___ TransMale/Man ___ TransFemale/Woman ___ Other _____

Relationship Status:
Dating ___ Married ___ Separated ___ Divorced ___ Widowed ___ N/A ___

Children:
Yes ___ No ___ # of Children _____ Ages or Age Range: _____

Home Address: _____

County of Residence: _____

Home Phone: _____ Work or Cell Phone: _____

Email: _____ May we email you? Yes ___ No ___
(Please note: Email correspondence is not considered to be a confidential medium of communication.)

How did you hear about us? _____

EMERGENCY CONTACT:

Contact Name: _____ Relationship to Client: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

PRIMARY CARE PHYSICIAN OR MEDICAL PROVIDER CONTACT:

Physician's Name/Phone: _____

MENTAL HEALTH/BEHAVIORAL INFORMATION:

Reason for Seeking Services: _____

_____

Recent Treatment History (last 12 months): _____

_____

Have you in the past received any type of mental health services (psychotherapy, psychiatric services, etc.)?

Yes ____ No ____ Yes, previous therapist/practitioner: _____

Pertinent Mental Health Issues: _____

_____

Have you ever been prescribed psychiatric (mental health) medications? Yes _____ No _____

Are you currently taking any psychiatric (mental health) medications? Yes _____ No _____

Please list: _____

Pertinent Medical Issues: _____

_____

Are you currently taking any prescription medications? Yes _____ No _____

Please list: _____

_____

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. Please list any difficulties you experience with your appetite or eating patterns.

   _____

4. Are you currently experiencing overwhelming sadness, grief or depression? Yes ___ No ___

5. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes ___ No ___

6. Are you currently experiencing any chronic pain? Yes ___ No ___

   If yes, please describe: _____

   _____

7. Do you drink alcohol more than once a week? Yes ___ No ___

8. Do you engage in recreational drug use? Yes ___ No ___

   If yes, how often? Daily ___ Weekly ___ Monthly ___ Occasionally ___

9. If you are NOT married, are you currently in a relationship? Yes ___ No ___

   If yes, for how long? _____

10. Are you currently employed? Yes ___ No ___

    If yes, what is your occupation? _____

    Is it full-time or part-time work?_____

    Do you enjoy your work? Yes ___ No ___

CONSENT FOR TREATMENT:

I hereby acknowledge that the information I provided on this form is true. Also, I give my consent for **SOLAY Counseling** to provide mental health services to me. I understand that I may withdraw my consent and refuse any services offered at any time.

Client: _____ Date: _____