



Benjamin Deu, MA Counseling Psychology
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Case Number:
Initial Appointment:

Intake Form

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Sex (M/F) _____ Birth Date _____ SS# _____

May I contact you by email for scheduling purposes? _____

Email Address: _____

Local Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

Cell Phone _____ *Can I call you here?* _____ *Can I leave a message?* _____

I typically will not identify myself as calling from Greenlake Counseling when I call, in order to protect your privacy. Due to a variety of factors, sometimes peoples are difficult to reach or never receive messages. Please call me back if you do not hear from me in a reasonable time.

How did you hear about us? Dex Online Google Other Website: _____

Referred By: _____ Has anyone urged you to come here? _____

Briefly tell us about the concerns that have brought you here.

Please check any current or past issues that still affect you.

- _____ Eating Disorders
- _____ Academic Issues
- _____ Childhood Abuse (*i.e. physical, sexual, emotional*)
- _____ Stress/Anxiety
- _____ Phobias (*type: _____*)
- _____ Alcohol/Other Drug Use
- _____ Sexual Assault/Rape
 - _____ *recently (when: _____)*
 - _____ *in the past*
- _____ Death of a someone close
 - _____ *recently (when: _____)*
 - _____ *in the past*
- _____ Family Issues (*i.e. divorce, alcoholism, domestic violence*)
- _____ Other: _____

- _____ Pregnancy Issues
- _____ Spiritual Concerns
- _____ Depression
- _____ Pornography
- _____ Sexual Identity Issues
- _____ Relationship Concerns
 - _____ *family*
 - _____ *friend*
 - _____ *parent*
 - _____ *significant other*
 - _____ *roommate*
 - _____ *other: _____*
- _____ Suicidal Thoughts

Your History

Current medical problems _____
 Current medications (*all, including herbal*) _____
 Are you currently working with any Personal Physician? _____ Phone Number: _____
 Name _____ What for? _____
 Have you been on any medications in the past for mental health issues? _____
 (*Please list*) _____

Have you previously seen a therapist? _____ Who/Where? _____
 How long ago? _____ For what types of issues? _____
 Are you currently seeing a therapist? _____

Have you ever been hospitalized for physical or mental health issues? (*Briefly describe*) _____

Have you had any previous suicide attempts? _____ (*Briefly describe*) _____

If you currently experience any of the following symptoms, please rate them using the key below.

<i>Never = 0</i>	<i>Seldom = 1</i>	<i>Often = 2</i>	<i>Always = 3</i>
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- | | |
|--|--|
| _____ Difficulty concentrating
_____ Crying
_____ Missing classes
_____ Feeling helpless
_____ Feeling uptight
_____ Worrying
_____ Feeling hopeless
_____ Feeling afraid
_____ Lying to others
_____ Feeling out of control
_____ Feelings of self-doubt
_____ Injuring self
_____ Nervous around others
_____ Suicidal Thoughts | _____ Memory loss or blackout
_____ Difficulty sleeping
_____ Stealing
_____ Anger
_____ Eating binges
_____ Drinking heavily
_____ Other drug use
_____ Guilt feelings
_____ Withdrawing socially
_____ Sexual preoccupation
_____ Physical symptoms (<i>i.e. headaches, digestive</i>)
List: _____
Have you seen a health care provider for these? _____
Other: _____ |
|--|--|

Would you be interested in a counseling group? _____ For what issues/topics? _____

Please use the scale below to answer the following questions.			
4= True to a great extent	3= Mostly true	2= Somewhat true	1= Not at all true
My current concerns affect my success in life.			_____
My current concerns affect my ability to interact and connect with others.			_____
I am optimistic that I will be able to make some positive changes as a result of counseling.			_____