

You may download and fill out digitally or by hand. Please bring to your first appointment.

TX CODE: _____

DX CODE: _____

Therapist: _____

Hope Hill Counseling
Intake Form

Patient Information

*PATIENT'S FULL NAME _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

*PATIENT'S DOB: _____ PHONE: _____

*PATIENT'S EMAIL ADDRESS: _____

Text capable? Yes__ No__

PATIENT'S SEX M _____ F _____

STATUS: Single__ Married__ Employed__

Full Time Student__ Part Time Student__

PATIENT'S RELATIONSHIP TO INSURED: Self__ Spouse__ Child__ Other_____

*SOCIAL SECURITY NUMBER _____

Insured's Information:

(the insured is the person who owns the policy, or employee to whom a group policy is applicable)

NAME OF INSURED: _____

STREET ADDRESS OF INSURED: _____

CITY, STATE, ZIP CODE: _____

INSURED'S DOB: _____ INSURED'S PHONE: _____

INSURED SOCIAL SECURITY NUMBER: _____

INSURANCE PLAN OR PROGRAM NAME: _____

INSURED'S INSURANCE ID: _____

POLICY GROUP #: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to

_____ and authorize _____ to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

Signature: _____

Personal Information

Name: _____

DOB: _____ Gender: _____ Date: _____

Address: _____

Home Phone: (_____) _____ -- _____ OK to leave a message? Y / N

Cell Phone: (_____) _____ -- _____ OK to leave a message? Y / N

Email address: _____

Relationship Status (circle):

Single Dating Engaged Married Cohabiting Separated Divorced Widowed

Current Partner's Name: _____ Phone: _____

Years Together (dating, married, etc): _____ Anniversary: _____

Number of Children: _____ Ages: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us?

Personal Experience

Where were you born? _____

Where did you grow up? _____

Were there any unusual circumstances regarding your conception or birth?

Were your parents married when you were born? Y / N

Are your parents currently married? Y / N

If your parents divorced, how old were you and why did it occur?

What is/was your mother like? How did she treat you as a child?

What is/was your father like? How did he treat you as a child?

How did your parent(s) typically discipline you?

What were your favorite things to do as a child?

List your siblings, and their ages in chronological order (oldest to youngest):

Name: _____ Age: ____ Relation (circle): Full Half Step

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Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

Name: _____ Age: ____ Relation (circle): Full Half Step

What was your birth order? 1 2 3 4 5 6 7 8 9 10

How many different places did you live before you finished high school?

Circle any of the following that describes your family and home atmosphere as a child:

Alcoholism Democratic Neglectful Prejudice Stable Affectionate Distant
No-fun Rigid Cold Angry Fighting Overprotective Sexual abuse Poverty
Close Frightening Physical abuse Mental illness Trusting Competitive
Moving excessively Physical illness Supporting Safe

Did anyone in your family die before you were 18? Y / N Who: _____

How old were you? _____

Did anyone in your family attempt or commit suicide? Y / N

Who: _____ How old were you? _____

Social Experience

Explain and indicate how satisfied you are with your current social life:

Describe your relationship with your best friend and how often you get together:

When did you first begin dating? Were your early dating experiences positive?

Education and Employment Experience

Highest grade in school or degree(s) completed:

Briefly explain the number of times, what grades, and the reason you had to change schools while growing up:

Are you currently employed? Y / N Position: _____

Time in current job: _____

Spiritual Experience

Please describe your family's spiritual or religious atmosphere while you were growing up: _____

When did you develop your current beliefs?

List a few words to describe your personal beliefs:

Do your family and friends share your current beliefs?

Any religious or spiritual problems that concern you?

Medical History

When was your last physical examination? _____

Name of your physician? _____

List any injuries, accidents, or surgeries:

List any head injuries, seizures, or loss of consciousness you have had:

List any medications (prescription and non-prescription) that you are taking:

Do you or your family members currently have or have ever had any of the following: (check all that apply)

	Self	Family
Heart problems	_____	_____
Cancer	_____	_____
Nervous breakdown	_____	_____
Stroke	_____	_____
Chronic illness	_____	_____
Alcohol or drug use	_____	_____
Legal problems	_____	_____
Learning disability	_____	_____
Depression	_____	_____
Other _____	_____	_____

Chemical/Substance History

Does/did anyone in your family use alcohol or drugs
(either prescription or street drugs) Y / N

What alcoholic beverages did/do you use? _____
How much? _____ How often? _____

When did you have your last drink? _____

What street drugs did/do you use? _____

When did you last use? _____

Do you use nicotine? _____ How much daily? _____ Caffeine? _____
How much daily? _____

Mental Health History

Have you ever been in counseling or therapy before?

In a few words describe your counseling experience:

Have you even been hospitalized for an emotional/mental health disturbance?
Y / N Describe: _____

Have you ever tried to end your own life? Y / N

If yes, please provide date(s): _____