Horgan & Saling Counseling Services LLC
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INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as your therapy sessions.

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

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

Name of parent/guardian (if you are a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status:
□Never Married □Partnered □Married □Separated □Divorced □Widowed

Number of Children: _____

Local Address: _____
(Number and Street)

_____
(City) (State) (Zip)

Home Phone: ( ) - May I leave a message? Yes No

Cell/Other Phone: ( ) - May I leave a message? Yes No
May I send texts? Yes No

Email: _____ May I email you? Yes No
** Please be aware that email might not always be confidential*

Who do you live with? _____

Referred by: _____

Are you currently receiving psychiatric services, counseling or psychotherapy? Yes No

If yes, please explain: _____

Have you had previous psychotherapy? Yes No

If yes, please explain: _____

Are you currently taking prescribed psychiatric medication (antidepressants/others)? Yes No

If yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. Sexual orientation: _____

2. Are you currently in a romantic relationship? Yes No

If Yes, how long have you been in this relationship? _____

On a scale of 0-10, how would you rate the quality of your current relationship? _____

3. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

4. Please list any persistent physical symptoms or health concerns (i.e., chronic pain, headaches, hypertension, diabetes, etc.)

_____

_____

_____

5. Are you having any problems with your sleep habits? Yes No

If Yes, check where applicable:

□Sleeping too little □Sleeping too much □Poor quality sleep

□Disturbing dreams □Other _____

6. How many times per week do you exercise? _____

7. Are you having any difficulty with appetite or eating habits? Yes No

If yes, check where applicable: □Eating less □Eating more □Binging □Restricting

Have you experienced a significant weight change in the last 12 months? Yes No

If yes, please explain: _____

8. Do you regularly use alcohol? Yes No

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

9. Do you have any history of recreational drug use? Yes No

Do you currently use recreational drugs? Yes No

If yes, how often? □Daily □Weekly □Monthly □Rarely □Never

10. Have you had suicidal/self-harm thoughts recently?

□Frequently □Sometimes □Rarely □Never

Have you had them in the past?

□Frequently □Sometimes □Rarely □Never

Have you had any suicide attempts? Yes No

If yes, please explain: _____

_____

11. Have you had thoughts of harming others recently?

□Frequently □Sometimes □Rarely □Never

Have you had them in the past?

□Frequently □Sometimes □Rarely □Never

12. Have you ever been arrested or convicted of a crime? Yes No

If yes, please explain: _____

_____

Do you have any guns or weapons at home or somewhere you can easily obtain them?

Yes No

13. In the last year, have you experienced any significant life changes or stressors? Yes No

If yes, please explain: _____

_____

Have you ever experienced:

Extreme depressed mood	Yes / No
Wild mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/Substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (i.e., obsessions)	Yes / No

Repetitive behaviors (i.e., frequent checking, hand washing) Yes / No
Suicide attempt Yes / No

FAMILY PHYSICIAN:

Do you currently have a general practitioner/Physician? Yes No

If yes, who is your current physician? _____

If no, when was the last time you saw a general practitioner? _____

If necessary, may we contact your physician with your consent? Yes No

EDUCATION/OCCUPATION INFORMATION:

Highest level of education completed & degree received: _____

Please list any learning disabilities: _____

Any history of behavioral/emotional problems during school years? Yes No

Are you currently employed? Yes No

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list history of any work-related problems: _____

Past occupations include: _____

Please list work-related stressors, if any: _____

_____

MILITARY HISTORY

Currently serving? Yes No N/A Branch: _____

Rank: _____

Past service? Yes No N/A Branch: _____

Rank: _____ Length of service: _____

□Honorable discharge (non-medical) □Honorable discharge (medical)

□Dishonorable discharge (specify reason) _____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? Yes No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes No

CHILDHOOD HISTORY:

Do you remember your childhood? Yes No Incomplete

Where were you born/raised? _____

Who raised you? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?
(Circle any that apply and list family member, i.e., sibling, parent, uncle, etc.):

Difficulty	**Family Member**	**Mom/Dad/Uncle/Aunt, etc.**
Depression	Yes / No	_____
Bipolar Disorder	Yes / No	_____
Anxiety Disorder	Yes / No	_____
Panic Attacks	Yes / No	_____
Schizophrenia	Yes / No	_____
Alcohol/Substance Abuse	Yes / No	_____
Eating Disorders	Yes / No	_____
Learning Disabilities	Yes / No	_____
Trauma History	Yes / No	_____
Suicide Attempts	Yes / No	_____

HISTORY OF PERSONAL ABUSE:

Do you have a history of personal abuse? Yes No

Have you experienced:	Physical Assault	Yes / No
	Domestic Abuse	Yes / No
	Rape or Sexual Molestation	Yes / No
	Emotional Abuse	Yes / No

	Verbal Abuse	Yes / No
	Deprived of food, shelter, medications, clothing	Yes / No
Have you inflicted on others:	Physical Assault	Yes / No
	Domestic Abuse	Yes / No
	Rape or Sexual Molestation	Yes / No
	Emotional Abuse	Yes / No
	Verbal Abuse	Yes / No
	Deprived of food, shelter, medications, clothing	Yes / No
	Elder abuse/neglect	Yes / No
	Abuse/neglect of child, children	Yes / No

Are you currently in an abusive situation? Yes No

If yes, please explain: _____

_____

OTHER INFORMATION:

What do you do with your leisure time (hobbies, special interests, volunteer work)?

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you have learned?

What are your goals for therapy?