refuge
Counseling

Client Intake & Background Information

Please answer all information as completely as possible. Information will be managed as Protected Health Information and is beneficial in providing you the best possible services. Feel free to ask for assistance, if needed. It is important you provide accurate information. Your counselor or student intern will discuss your responsibilities with you in your intake interview.

Please fill out one form per person seeking counseling

PROVIDER USE ONLY: Individual Couple Family Group Provider: _____

Name: _____ Date: _____ Time: _____

Gender: _____ Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

CIRCLE ONE: Married Cohabitating Separated Divorced Widowed Single Engaged

Referred By: _____

Phone: _____ May Call: YES NO Message*: YES NO

Alt. Phone: _____ May Call: YES NO Message**: YES NO

Email***: _____ May contact through email: YES NO

**This includes SMS text appt. notifications—you may choose "stop" to opt out of notifications.*
***Please notify your counselor if you have specific concerns/requests on how you would like to be contacted.*
****Email is not a confidential means of communication and is intended to be used on a limited bases such as the purposes of making, changing and cancelling appointments, or sending of minimal/basic information.*

Emergency Contact Name: _____ Relationship: _____

Emergency Number: _____

Would you like to request about third-party payment (non-insurance): YES NO

Have you ever been to counseling? YES NO If yes, when: _____

Reason: _____

If yes, did it help: _____

Have you ever contemplated ending your life? YES NO

Are you currently contemplating ending your life? YES NO

Has anyone in your immediate family attempted or committed suicide? YES NO

What are the major concerns for which you're seeking counseling?_____

_____

On a scale 1 (mild) to 5 (severe), how would you rate your issues? 1 2 3 4 5

How long have these issues been a concern?_____

Describe your personal strengths:_____

_____

Describe your support system (family, friends, church, etc):_____

_____

Would including spirituality in your counseling be helpful? YES NO

If yes, what is your religious background and/or preference?_____

General Health Screening

Are you currently under the care of a physician or psychiatrist: YES NO

Name(s) and Contact Info: _____

Please list any medications or naturopathic alternatives you take (use back if necessary): _____

_____

Date of last physical exam:_____ Any significant result: _____

Physical Disability: YES NO Chronic Illness: YES NO

If yes to either, please explain: _____

_____

_____

Mental Health Screening Form

Do you have any history of treatment from mental health professionals due to emotional or behavioral problems?:

YES NO

If yes, please answer A & B.

A. Are you currently under the care of a mental health professional: YES NO

B. How many years total have you received mental health services: _____

Additional Comments:_____

Have you ever been hospitalized for mental health reason? YES NO Date(s): _____

For what purpose(s): _____

Do you have any history of taking medications for mental health purposes: YES NO

Check any of the following symptoms that are concerns for you:

____ Anxiety
____ Aggression
____ Concentration
____ Crying Spells
____ Depression
____ Fatigue
____ Fear
____ Hallucinations
____ High Energy
____ Hopelessness
____ Hyperactivity
____ Impulsive Behaviors
____ Irritability
____ Intrusive Thoughts
____ Lack of Pleasure
____ Low Motivation
____ Nightmares
____Obsessive Thoughts
____ Panic Attacks
____ Restlessness
____ Substance Abuse
____ Sleeping Problems
____ Suicidal Thoughts
____ Trembling
____ Other: _____
____ Other: _____
____ Other: _____

How long have these symptoms been bothering you: _____

Check any of the following areas in which mental health concerns are affecting your functioning:

____ Emotionally ____ Marriage & Family ____ Physically ____ School ____ Sexually
____ Socially ____ Work ____ Spiritually ____ Other_____