



SEASONS COUNSELING ORLANDO

INSIGHT • HEALING • TRANSFORMATION

331 North Maitland Ave, Unit B3
Maitland, Florida 32751
(407) 960-3938
seasonscounselingorlando.com

CONFIDENTIAL INTAKE FORM

Full Name: _____ Date: _____

GENERAL INFORMATION

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth ____/____/____

Ethnicity: White Black Hispanic Asian Other Sex: Male Female

Email Address: _____

Phone (h): _____ May we contact you here? Yes No

Phone (c): _____ May we contact you here? Yes No

Phone (w): _____ May we contact you here? Yes No

May we leave a message for you? Yes No May we text you? Yes No

Occupation: _____ Place of Employment/School: _____

Education Level: High School; Some College; Bachelors Degree; Graduate School

Hours worked per week: _____ Estimated annual income: _____

How did you hear about us? Internet Physician Friend Parent Other

Name of person who referred you: _____

May we thank them for referring you? Yes No

What type of counseling are you seeking? *Please choose one and note Forms Required.*

Type	Description	Forms Required
<input type="checkbox"/> Individual	One-on-One Counseling	1 Intake Form per person
<input type="checkbox"/> Family	Two or more family members	1 Intake Form per person over 18 yrs.
<input type="checkbox"/> Relationship	Dating couples	1 Intake Form per person (2 total)
<input type="checkbox"/> Pre-Marital	Engaged couples or those considering marriage	1 Intake Form per person (2 total)
<input type="checkbox"/> Marital	Couples needing marital guidance	1 Intake Form per person (2 total)

RELATIONAL INFORMATION

Current relational status: Single Dating Engaged Married Separated Divorced Widowed

Are you content with your current relational status: Yes No (if no, briefly explain): _____

If married, how long: _____ Number of marriages for you: _____ For your partner: _____

If separated or divorced, how long: _____ If widowed, how long: _____

Partner's Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How long have you known your partner: _____ Their age: _____ Preferred name: _____

Partner's Ethnicity: White Black Hispanic Asian Other Partner's sex: Male Female

Partner's Occupation: _____ Hours worked per week: _____

Partner's Education Level: High school Some college Bachelors degree Graduate school

What words would you use to describe your partner?

Is your partner supportive of you seeking counseling? Yes No Unsure Partner doesn't know

List your children below (including step, adopted, foster):

Name	Sex	Age or year of death	Relationship to you	Living with you?

Have you ever placed a child for adoption? Yes No If yes, when? _____

Have you ever had a miscarriage or medical abortion? Yes No If yes, when? _____

List your mother, father, brothers, sisters, stepfamily relations, or any other family member who had a significant effect (positive or negative) upon your life:

Name	Age or year of death	Relationship to you	Describe this person.

PHYSIOLOGICAL INFORMATION

Describe your current health: [] Good [] Fair [] Poor Date of your last physical exam: ____/____/____

List any medical conditions, illnesses, treatments, or surgeries: _____

Check any of the following symptoms/sensations that apply to you presently, or in the recent past:

- Headaches Past Present Dizziness Past Present Stomach Trouble Past Present
- Visual Trouble Past Present Sleep Trouble Past Present Trouble Relaxing Past Present
- Weakness Past Present Tension Past Present Rapid Heart Rate Past Present
- Difficulty Breathing Past Present Intestinal Trouble Past Present Hearing Noises Past Present
- Change in Appetite Past Present Tiredness Past Present Pain Past Present
- Hearing Voices Past Present Seeing Things Past Present Other Past Present

Height: _____ Weight: _____ Weight change in the last 2-3 months: _____

List all current medications you are taking, including those you seldom use or take only as needed:

Name of Medication(s)	Dosage	Reason for taking

Are you presently experiencing suicidal thoughts? [] Yes [] No

Have you experienced them in the past? [] Yes [] No

Have you ever attempted suicide? [] Yes [] No If yes, when and how? _____

Have any friends or family committed suicide? [] Yes [] No If yes, when and how? _____

Are you presently experiencing any thoughts of harming another person? [] Yes [] No

COUNSELING HISTORY

List names of previous counselors, therapists, or mental health programs, including dates and contact information:

How do you feel about the results of your previous counseling?

Do we have permission to contact your previous counselor(s)? [] Yes [] No

Have you ever been hospitalized for psychiatric purposes? Yes No

If yes, please explain including name of hospital, location, and dates: _____

RELIGIOUS BACKGROUND (optional)

Do you believe in God? Yes No Religious preference: _____

Which church do you currently attend? _____

How much influence does your religion have on your day-to-day activity? Very little Some A lot

REASON FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

Where are your concerns causing the most problems for you? *Check all that apply.*

Home Work Marriage God Other Relationships (specify): _____

When did your present concern begin to become a problem for you? _____

Check any of symptoms or problems that you are currently experiencing. *Check all that apply.*

- | | | |
|--|--|---|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Panic | <input type="checkbox"/> Crying all the time |
| <input type="checkbox"/> Anxiety or worry | <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> Fatigue/Lack of energy | <input type="checkbox"/> Marital Problems | <input type="checkbox"/> Compulsive behaviors |
| <input type="checkbox"/> Poor appetite or overeating | <input type="checkbox"/> Other relational problems | <input type="checkbox"/> Seeing things others don't see |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Feeling worthless or inferior | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Verbal abuse | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Drug use | <input type="checkbox"/> Death of friend or loved one |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Abortion | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Terminal illness |
| <input type="checkbox"/> Bad dreams | <input type="checkbox"/> Work Stress | <input type="checkbox"/> Health concerns |
| <input type="checkbox"/> Unwanted memories | <input type="checkbox"/> Career choices | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Loss of control | <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Fears |
| <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Lack of discipline | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Controlling | <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> Controlled by others | <input type="checkbox"/> Spiritual apathy | <input type="checkbox"/> Don't like myself |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Have any concerns about you been identified by others? _____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

<i>Minimally Distressing</i>	<i>Moderately Distressing</i>	<i>Extremely Distressing</i>
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What do you hope to gain or change by coming to counseling at this time?

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____