James Goodmon Counseling, LLC

Intake Form

Please provide the following information by answering questions below. Information provided is protected as confidential information. If couples, please fill out individually.

NAME: _____ Maiden Name: _____
Last First Middle Initial (if applicable)

Name of Parent/Legal Guardian if under 18 years of age:

_____
Last First Middle Initial

Address: _____

_____

Cell phone: (_____) _____. May we leave a message and/or text? ☐ YES ☐ NO

Email: _____ May we email you? ☐ YES ☐ NO

Age: _____ Date of Birth:_____/_____/_____

Gender: ☐ MALE ☐ FEMALE

Marital Status: ☐ SINGLE ☐ MARRIED ☐ PARTNER
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Employer or School _____

Position/Title or grade_____

Education/degree _____

Person/Agency/Referral Source _____

Physician: _____ Phone: _____

In case of emergency, contact_____
Name/Relationship Phone Number

Previous counseling or psychiatrist experience:

_____

_____

Dates/With Whom

MARRIAGE AND FAMILY INFORMATION (If applicable):

Spouse: _____ Age: _____ Date of Birth_____

Employer & Position: _____

Education/Degree _____

Date of Marriage: _____Length of dating Relationship: _____

How did you meet:

_____

Children:

Name: _____ Male/Female Age: _____

Name: _____ Male/Female Age: _____

Name: _____ Male/Female Age _____

Name: _____ Male/Female Age_____

Name: _____ Male/Female Age_____

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General Health:

1. Describe your health_____

2. Do you have any chronic conditions? _____

3. Current medications and dosage_____

_____

Have you ever been prescribed psychiatric medication? ☐ YES ☐ NO

If yes, provide dates: _____

4. Do you drink alcohol? ☐ YES ☐ NO

If yes how frequently? and how much? _____

5. Do you currently or have you in the past used recreational drugs? ☐ YES ☐ NO

If yes, please describe: _____

6. Have you ever had a severe emotional upset? ☐ YES ☐ NO

If yes, please explain_____

7. Have you ever experienced a concussion? ☐ YES ☐ NO

If yes, please list dates and experiences:

_____

8. How many days per week do you exercise? _____

9. If you exercise, what types of exercise do you participate in? _____

_____

10. How many hours per night do you sleep? _____

11. Do you have specific sleep issues? _____

Emotional Health:

Please CHECK any of the following words which describe you now:

- ☐ Active
- ☐ Persistent
- ☐ Impulsive
- ☐ Imaginative
- ☐ Shy
- ☐ Likable
- ☐ Fearful
- ☐ Lonely
- ☐ Obsessive
- ☐ Ambitious
- ☐ Nervous
- ☐ Kind
- ☐ Calm
- ☐ Good-natured
- ☐ Leader
- ☐ Submissive
- ☐ Sensitive
- ☐ Hopeful
- ☐ Moody
- ☐ Hardworking
- ☐ Sad
- ☐ Serious
- ☐ Introvert
- ☐ Quiet
- ☐ Spiritual
- ☐ Anxious
- ☐ Self-confident
- ☐ Impatient
- ☐ Excitable
- ☐ Easy-going
- ☐ Extrovert
- ☐ Angry
- ☐ Self-conscious
- ☐ Regimented

Issue Check-List:

- ☐ Anger
- ☐ Fear
- ☐ Guilt
- ☐ Impotence
- ☐ Children
- ☐ Grief
- ☐ Eating Disorder
- ☐ Change in Lifestyle
- ☐ Envy
- ☐ Memory
- ☐ Rebellion
- ☐ Addiction
- ☐ Abuse
- ☐ Apathy
- ☐ Chronic Illness
- ☐ Sadness
- ☐ Appetite
- ☐ Moodiness
- ☐ Health
- ☐ Depression
- ☐ Deception
- ☐ Family
- ☐ Blended Family
- ☐ Anxiety
- ☐ Bitterness
- ☐ Sex
- ☐ Work
- ☐ In-Laws
- ☐ Spouse
- ☐ Panic Attacks

Family History:

Father and Mother married or divorced? if married how many years? _____

If divorced at what age were you? _____

How did your parent's relationship impact

you?_____

_____

Siblings: _____Older Brother/s _____Older Sister/s

_____Younger Brother/s _____Younger Sister/s

What is your birth order? oldest, middle, youngest, only

_____

In the section below, identify family history of any of the following. If yes, please indicate the family member's relationship to you.

			Family Member/Self
Alcohol/Substance Abuse/Addiction	☐ YES	☐ NO	_____
Post-Traumatic Stress Disorder	☐ YES	☐ NO	_____
Anxiety	☐ YES	☐ NO	_____
Adoption	☐ YES	☐ NO	_____
Depression	☐ YES	☐ NO	_____
Hoarding	☐ YES	☐ NO	_____
Eating Disorders	☐ YES	☐ NO	_____
Suicide Attempts	☐ YES	☐ NO	_____
Obesity	☐ YES	☐ NO	_____
Neglectful Abuse	☐ YES	☐ NO	_____
Emotional Abuse	☐ YES	☐ NO	_____
Physical Abuse	☐ YES	☐ NO	_____
Sexual Abuse	☐ YES	☐ NO	_____
Obsessive Compulsive Disorder	☐ YES	☐ NO	_____
Known Trauma	☐ YES	☐ NO	_____

Please briefly answer the following questions:

1. What brings you in to counseling?

2. What have you tried to do about this?

3. What do you hope to accomplish through counseling?

4. What do you consider your strengths?

5. What do you consider your weaknesses?

6. Do you consider yourself to be spiritual? What are your beliefs?

7. Is there any other information for the counselor to know?

_____	_____	_____
Client Print	Signature	Date
_____	_____	_____
Print Parent/Guardian if under 18	Signature of Parent/Guardian	Date

_____	_____
Signature of Counselor	Date