Official Intake Form
Austin, TX
737-781-3028

Name: _____Age: _____Date of Birth: _____

Marital Status: _____

Home/Cell Phone: _____Email Address: _____

Address: _____ City: _____Zip: _____

Language & Religion & Culture Awareness: _____

Who Are You?

1. Favorite Color: _____

2. Favorite Food: _____

3. Fun Fact: _____

Hobbies or Interest:

1. _____

2. _____

3. _____

Who referred you to therapy Name and Number:

_____

_____

Therapy in the Past, If yes, please describe with whom, when, how long, and for what:?

_____

What are your three reasons for seeking counseling today?

1. _____

2. _____

3. _____

How long has this been an issue?

_____

What are your goals for seeking counseling today?

1. _____

2. _____

3. _____

How would you know when things are better?

1. _____

2. _____

3. _____

What have you tried to help these issues?

1. _____

2. _____

3. _____

What do you consider your greatest strengths?

1. _____

2. _____

3. _____

What are your three weaknesses or barriers?

1. _____

2. _____

3. _____

Who do you consider as your greatest support?

1. _____

2. _____

3. _____

Extended and Immediate Family History

Please indicate if you, your immediate and/or extended family have history of the following:

	Who		Who
Divorce		Depression	
Alcohol/Substance Abuse		Anxiety	
Physical Abuse		Suicide	
Sexual Abuse		Psychosis	
Emotional Abuse		Eating Disorder	

Current/Recent Mood: Please check your general state in the past 2 weeks:

	Anxiety		Fear		Sadness		Grief		Irritability
	Happy		Impatient		Calm		Numb		Anger

	Lost								

Please check changes or concerns involving the following

	Finances		Legal		Work/Job		Education/School		Moving
	Marital		Parenting		Concentration		Memory		Energy
	Health/Illness		Surgery/Injury		Grief/Loss		Family Addition		Family Leaving
	Mood Swings		Sexual Activity		Sleep Habits		Eating Habits		Caffeine Intake
	Tobacco Use		Alcohol Use		Drug Use		Blackouts		Family Member

Do You Currently have any Medication Treatment?

Dosage:	Name:	How Often:

Name of Psychiatrist, Address and Phone Number:

_____

_____

_____

Name of Primary Care Provider, Address and Phone Number:

_____

_____

_____

History of Surgeries/ Health Problems or Allergies:

1. _____

2. _____

3. _____

History of Inpatient at Mental Health Hospital or Substance Treatment Center and Why?

1. _____

2. _____

3. _____

Is there currently use of Alcohol or Substances use? If so please list

1. _____

2. _____

3. _____

Education System and Workforce:

Highest Grade Level completed or currently in:	School or program:	Special Education or 504 Plan:
Employed?	How Long:	Are You in You Dream Job?

Emergency Contact

Name: _____ Relationship: _____

Home/Cell Phone: _____ Email Address: _____

Address: _____ City: _____ Zip: _____

Additional Information:

Client Name: _____

Intake Date: _____

Client Signature: _____

Shavon Mariah Social Services

Name and Credentials: _____

Intake Date: _____