ARCADIA
Counseling & Consulting Services, LLC.

Intake Form

Name: _____ Date: _____

Gender: _____ Date of Birth: _____

Social Security #: _____ Ethnicity/Race: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone Numbers:

Primary: _____ May I leave a message here? Yes ___ No ___

Secondary: _____ May I leave a message here? Yes ___ No ___

Email: _____ May I leave a message here? Yes ___ No ___

Relationship Status: (circle one) Single Partnered Married Divorced Widowed Other

Sexual Orientation: (circle one) Hetero Lesbian/Gay Bisexual Asexual Pansexual Other

Gender Identification: (circle one) Female Male Trans Other

Student Status: (circle one) Full-time Part-time Not a Student

Highest Educational Level Achieved: _____

Responsible Party **(if different from above):** _____ Date of Birth: _____
Address: _____ Okay to mail? Yes __ No __
Contact Phone Numbers:
Primary: _____ May I leave a message here? Yes __ No __
Secondary: _____ May I leave a message here? Yes __ No __

Who should I contact in an emergency?
Name: _____ Phone: _____ Relationship: _____

Primary Insurance: _____ ID#: _____

Group #: _____ Subscriber Name: _____

Insurance Phone: _____ Subscriber DOB: _____

Workplace/Title: _____School: _____

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Please state spiritual beliefs: _____

Religious Affiliation: _____

Please list legal issues: _____

MEDICAL HISTORY

List any medical conditions / history (surgeries, broken bones, allergies, pregnancies, headaches, etc.):

_____

_____

_____

Do you use:

Tobacco ___ Alcohol ___ Drugs ___ (Kind _____) Caffeine _____

Specify amount and frequency: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Last seen: _____

May Arcadia communicate with your Primary Care Physician? Yes ____ No ____

Other health professional: _____ Phone: _____

Address: _____ Last seen: _____

May Tracey McCarthy communicate with your other health professional? Yes ____ No ____

Current Medications, Supplements and Dosages:

_____

_____

Do you exercise? Yes ___ No ___ If 'yes" what type and how often? _____

_____

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FAMILY INFORMATION (history and present):

As a minor, did you experience:

Separation from mother or father _____ Out of Home Care _____ Disruption in Bonding _____

Depression of parent _____ Abuse _____ Neglect _____ Parental Stress _____

If yes to any of these, please explain: _____

_____

Language spoken at home: _____

As an adult, have you experienced:

Separation from partner or spouse _____ Depression of partner / spouse / child _____ Abuse _____

Chronic Pain _____ Family Stress _____ Neglect _____ Marital Stress _____ Work Stress _____

If yes to any of these, please explain: _____

_____

Have you reached your life goals: On time _____ Early _____ Late _____

Please specify: _____

_____

What are five words to describe:

Mother: _____

Father: _____

Parents' Relationship: _____

Siblings: _____

Children: _____

Partner / Spouse: _____

Did your parents separate or divorce when you were a minor? Yes _____ No _____

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People in your household growing up (Name, relationship, DOB):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any mental health diagnosis in the family: _____

_____

List any addictions (food, drugs, alcohol, gambling) in the family: _____

_____

Did you witness parental arguments as a minor? Yes _____ No _____

Did you witness domestic violence as a minor? Yes _____ No _____

How were you disciplined? _____

People in your household currently (Name, relationship, DOB):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a partner or spouse, how do you resolve disagreements? _____

List any addictions (food, drugs, alcohol, gambling) in the family: _____

_____

Have you been abused by your partner or spouse? Yes _____ No _____

Have you abused your partner or spouse? Yes _____ No _____

How do you discipline your children (if applicable)? _____

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PREVIOUS MENTAL HEALTH PROVIDER:

Name: _____ Dates: _____ Diagnosis: _____

TRAUMA HISTORY:

Have you been verbally abused? Yes _____ No _____ Specify: _____

Have you been physically abused? Yes ____ No _____ Specify: _____

Have you been sexually abused? Yes ____ No _____ Specify: _____

Other stressors or trauma: _____

Circle the symptoms you have and indicate the number of times per week you have them:

Anger ___	Anxiety ___	Bedwetting ___	Conduct Problems ___
Controlling ___	Defiance ___	Depression ___	Dissociation ___
Drug / Alcohol Use ___	Homicidal Thoughts ___	Homicidal Acts __	Hyperactivity ___
Lack of empathy ___	Lack of motivation ___	Lethargy ___	Low impulse control ___
Low self-worth ___	Lying ___	Nightmares ___	Stomach/headaches ___
Obsessions ___	Compulsions ___	Overeating ___	Suicidal Thoughts ___
Suicidal Acts ___	Cutting ___	Self-injurious acts ___	Peer Problems ___
Phobias ___	Running away ___	Shy ___	Sleeplessness ___
Startle easily ___	Stealing ___	Tantrums ___	Undereating ___
Vomiting ___	Sexual Acting-out: ____	Other Symptoms: _____	

Circle the feelings that apply to you most often:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others: _____	

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Circle the physical symptoms that apply to you most often:

Headaches	Stomach trouble	Skin Problems	Dizziness
Dry mouth	Palpitations	Fatigue	Excessive sweating
Muscle spasms	Chest pains	Tension	Back pain
Rapid heartbeat	Blackouts	Don't like being touched	Fainting spells

How do you handle anger? _____

What are your hobbies/volunteer activities? _____

What are your strengths? _____

What brings you to counseling? _____

_____

_____

What are your goals for counseling and what do you hope to accomplish? _____

_____

What obstacles can get in the way of accomplishing these goals? _____

If you have been in counseling before:

What was helpful? _____

What was not helpful? _____

Please print the name of the person filling out this form: _____

_____ _____

Signature Date

Thank You!