Reflections Counseling

Client Intake Form

Thank you for selecting Reflections Counseling. In order to better meet your needs we require the following information. Please complete this form prior to your intake appointment.

Client Information

Full Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Mailing Address: _____

Occupation Status: _____ City, State, Zip Code: _____

Preferred Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Alternate Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Email: _____ Okay to email? ☐ Yes ☐ No

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female ☐ Other _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Insurance Information and Finances *(Please complete the following and bring your Insurance Card)*

Insurance Company: _____ Subscriber's ID #: _____(Include Alpha Prefix)

Policyholder's Name: _____ Date of Birth: _____

Employer Name: _____ Group #:_____
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Partner Office Co-Pay or Co-Ins: _____

Person financially responsible for this account (if patient if a minor, the parent/guardian bringing them is the responsible party): _____

Mailing Address: _____

Health History

Date of Last Physical: _____ Physician's name: _____

Health Problems (major illnesses, conditions, surgeries, or recent diagnoses): _____

_____

_____

_____

Medications and Supplements (name, dosage, reason/associated condition): _____

_____

_____

_____

Do you exercise regularly? ☐ Yes ☐ No If yes, what type and how frequently? _____

_____

Are you a smoker? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No Do you use drugs? ☐Yes ☐ No

Are you, or is someone you know, concerned about your substance use? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Areas of Concern

Please rate on a scale of 1-5 (*using the scale provided below*) to rate the amount of concern your problem is causing in each of the following areas by placing a corresponding number next to the symptom.

Scale:	**Symptom:**
1. No Concern	Depression _____ Ability to Concentrate_____ Appetite _____
2. Some Concern	Thoughts of Suicide _____ Alcohol/Drug _____ Stress _____
3. Moderate Concern	Anger _____ Relationships _____ Sleep/Fatigue _____
4. Serious Concern	Physical Health _____ Anxiety _____ Memory Loss _____
5. Very Serious	Family Conflict _____ Grief _____ Lack of Motivation _____

Coordination of Care

Do you authorize Reflections Counseling to release information to your health care provider?

☐ I authorize ☐ **I do not authorize**

Primary Care Physician: _____ Phone: _____

Clinic Name and Location: _____

_____

Counseling Goals

Have you had previous counseling? ☐ Yes ☐ No If yes, when, and for how long? How was it helpful?

_____

_____

_____

What specific event(s) or experience(s) have led you to seek counseling now? _____

_____

_____

_____

_____

What are you hoping to gain from counseling? _____

_____

_____

_____

_____

What strengths do you possess that will be helpful in meeting your goals? _____

_____

_____

_____

_____

What limitations could get in the way of you meeting your counseling goals? _____

_____

_____

_____

How were you referred to Reflections Counseling? _____

_____