Heel to Heal
COUNSELING

Client Intake Form

Name			Nickname
Gender	Date of Birth	Marital Status	Employment Status
Home Address			
City, State, Zip			
Home Phone		Work Phone	
Cell Phone		Cell Phone Carrier	
Email Address			
Emergency Contact (Name, relationship, phone)			

How would you like appointment reminders to be sent to you?

❑ Email ❑ Text Message ❑ Phone Call ❑ None

If insurance will be used, please fill in the following

Insurance Company	
Insured Person's Name (usually the employee)	
Insured's Street Address	
Insured's City, State, Zip	
Insured's Phone Number	
Insured's Date of Birth	Insured's Gender
Employer (of the insured)	
I.D. Number (found on the insurance card)	
Group Number (if on insurance card)	
Insurance Phone Number (usually on card's back)	

Why are you seeking counseling? _____

_____

_____

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Check the box beside each concern experienced recently.

- ☐ Anxiety
- ☐ Panic
- ☐ Crying spells
- ☐ Treated unfairly
- ☐ Restlessness
- ☐ Drug use
- ☐ Stress
- ☐ Guilt feelings
- ☐ Compulsions
- ☐ Specific fears
- ☐ Feeling abandoned
- ☐ Irritability
- ☐ Religious concerns
- ☐ Feeling inferior
- ☐ Depression
- ☐ Unusual thoughts
- ☐ Memory problems
- ☐ Frequent pain
- ☐ Nausea
- ☐ Drinking problem
- ☐ Shyness
- ☐ Suspicion
- ☐ Worry
- ☐ Mourning
- ☐ Meaninglessness
- ☐ Social withdrawal
- ☐ Disappointment
- ☐ Irrational thoughts
- ☐ Sleep problems
- ☐ Anger outbursts
- ☐ Sexual problems
- ☐ Low energy
- ☐ Eating disorder
- ☐ Boredom
- ☐ Work problems
- ☐ Loneliness
- ☐ Money problems
- ☐ Physical illness
- ☐ Perfectionism
- ☐ Feeling misunderstood
- ☐ Impulsive
- ☐ Mood swings
- ☐ Thoughts of suicide
- ☐ Changes in weight
- ☐ Relationship difficulties
- ☐ Concentration problems
- ☐ Legal difficulties
- ☐ Hopelessness
- ☐ Confusion
- ☐ Thoughts of hurting others
- ☐ Difficulty with decisions
- ☐ Poor motivation
- ☐ Unusually sensitive
- ☐ Troublesome thoughts
- ☐ Hearing strange voices
- ☐ No problems or concerns

Other additional concerns or symptoms: _____

_____

What stresses or life changes have you experienced lately? _____

_____

Have you seen a therapist in the past?

Year	Problem	Therapist or clinic	How long

About your childhood

Check the box beside issues experienced in childhood

- ☐ Happy childhood
- ☐ Physically abused
- ☐ Weight problems
- ☐ Family fights
- ☐ Drug or alcohol use
- ☐ Depressed
- ☐ Not allowed to grow up
- ☐ Neglected
- ☐ Few friends
- ☐ Popular
- ☐ Poor grades
- ☐ Good grades
- ☐ 'Spoiled'
- ☐ Attention problems
- ☐ Moved frequently
- ☐ Sexually abused
- ☐ Parents divorced
- ☐ Conflict with teachers
- ☐ Sexual problems
- ☐ Anxious
- ☐ Anger problems

Additional childhood experiences or symptoms: _____

_____

Your family growing up

Relationship (also list siblings and other significant relationships)	First Name	Personality / Mental Health Issues
Mother		
Father		

Who lives with you now?

Relationship	First Name	Personality / Mental Health Issues

Where are you currently living? ❑ House ❑ Apartment ❑ With relatives
❑ Dorm/campus apartment ❑ Health care facility ❑ Retirement community ❑ Other

Relationship history

How many times have you been married?	How old were you at the time of your marriage(s)?
Briefly describe any problems in your current or past marriages or cohabitation relationships	

Education & Occupation

Are you currently… ❑ Working ❑ In school ❑ (both) ❑ (neither)
Highest level of education so far?
What is (or was) your major or favorite subject?
How many hours per week are you working?
In what field do you usually work?
What is your current or most recent job title?
Briefly describe what you like and dislike about your employment or school

Home Life

How do you spend personal time? (list hobbies, sports, clubs, groups, family activities, etc.)
How many contacts do you have each month with friends outside of work or school?
Who can you talk with about personal feelings or private matters?
Are you satisfied with your romantic life?
Briefly describe what you like and dislike about your current romantic and friendship lives:

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Health

Check the box beside each accident or illness you have experienced

- ☐ Recent surgery
- ☐ Seizures
- ☐ Drug/alcohol abuse treatment
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Infertility
- ☐ Head injury
- ☐ Thyroid problems
- ☐ Neurological disorder
- ☐ Headaches
- ☐ Hormone problems
- ☐ Miscarriages

List any other chronic health problems you may have:
How many hours do you sleep in an average night?
How many drinks (containing alcohol) do you consume in an average week?
Which recreational drugs have you used in the last year?
List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:
Do you exercise? How? How often?
Do you use tobacco? How much?
Who is your primary physician? (Include phone number if known)
When was your last physical?
Are you concerned about your physical health?

Accomplishments / Additional Information

List your personal strengths and important accomplishments
List any additional information that it might be important for your counselor to know