Counseling Connections

MENTAL HEALTH COUNSELING CONNECTIONS, PLLC

Intake Form

Please take a moment to answer the following questions. Please be aware that the information that you provide here is protected as confidential information.

Please fill out this form and bring to your first session.

Today's Date*:* ___ / ___ / ___

Name:

_____

(Last) (First) (Middle)

Address: _____

(Street and Number)

_____

(City) (State) (Zip Code)

Name of Parent/Legal Guardian (if under the age of 18):

_____

(Last) (First) (Middle)

Home Telephone: (____)_____May we leave a message? ____ yes ____ no

Cellular/Other Telephone: (___)_____May we leave a message? ____ yes ____ no

E-mail Address: _____ May we e-mail you? ____ yes ____ no

*Please note: E-mail correspondence is not considered to be a confidential medium of communication.

Birth Date: ___ /___ / ___ **Age**: _____

Race/Ethnicity: _____ **Gender**: Male: ___ Female: ___Other_____

Referred by (if any): _____

Anne Marie Farage-Smith LMHC
Crossbridge Office Park, 2000 S. Winton Road
Building 4 Suite 200 Rochester, N.Y. 14618
585-615-5492

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Your Employer: _____

Employer's Address: _____

Employer's Telephone: (____)_____ **Permission to call?** ____ yes ____ no

Are you a student? Full time_____ Part-Time_____ Where?_____
Did you graduate high school? _____ If not, what grade did you leave school and why?_____

Emergency Contact: _____

Telephone: (____)_____ **Relationship:** _____

Marital Status: ____ Never Married ____ Separated
____ Divorced ____ Committed Relationship/Domestic Partnership
____ Widowed ____ Married

Please list any children (names/ages), including step-children, adopted, etc.:

_____

Please briefly describe your family of origin (i.e. who raised you, who lived in the home while you were growing up, what was/is your relationship like with your parents/siblings/etc.):

_____
_____
_____
_____
_____

Have you received any type of mental health services in the past (psychotherapy, psychiatric services, etc.)?
____ No
____ Yes, please list previous providers and dates: _____
_____

May we contact them? ___ No ___ Yes (additional release needed for contact)

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Are you currently taking any prescription medication?
____ No
____ Yes, please list: _____
_____

Have you ever been prescribed psychiatric medication in the past?
____ No

____ Yes, please list and provide dates: _____

Please complete the following regarding your mental health:

Check off any of the following boxes if you have experienced this issue in the past six months:

- ☐ Anxiety
- ☐ Panic Attacks *Please describe: _____
- ☐ Depressed Mood
- ☐ Fear
- ☐ Decreased Sleep
- ☐ Increased Sleep
- ☐ Relationship Concerns
- ☐ Anger
- ☐ Increased Appetite
- ☐ Decreased Appetite
- ☐ Increased alcohol/drug consumption *When was your last use? _____ What did you use?_____
- ☐ Racing Thoughts
- ☐ Delusions
- ☐ Hallucinations
- ☐ Hopelessness
- ☐ Increased Energy
- ☐ Trauma
- ☐ Loss
- ☐ Inability to Focus
- ☐ Medical Concerns
- ☐ Chronic Pain
- ☐ Self-Harming Behaviors
- ☐ Tearfulness
- ☐ Legal Problems *Any prior legal history (what and when)? _____
- ☐ Suicidal Thoughts *Any suicidal plan or intent? _____
- ☐ Suicide Attempt *Any prior suicide attempts (when/how)?_____
- ☐ Violent Thoughts *Any prior history of violence (when/who/how?)_____
- ☐ Other: _____

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How long have you been experiencing these issues? _____

Briefly describe any of the symptoms that you checked above?_____

Please list any current/past medical/physical conditions: _____
_____

Please list any family history of physical/mental health conditions (condition/person's relationship to you):

Please describe any (past or current) history of trauma or abuse: _____

How often do you drink alcohol? ____Daily ____Weekly ____Monthly ____Infrequently ____Never

How many drinks do you consume per use? _____
When was your last use of alcohol? _____

Have you ever been in treatment for alcohol/substance abuse? If so, when and where?

_____

Check each drug that you have used in the past or are currently using:

DRUG NAME	DATE OF LAST USE	HOW MUCH?	INDICATE CURRENT OR PAST USE
Marijuana			
Cocaine			
Heroin			
Tobacco			
Methamphetamine			
Benzodiazepines			
Ecstasy			
Inhalants			
Over-the-counter products			
Others:			

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On a scale of 1-10 (1- being very poor, 10- being very good), how would you rate your:

____ Family Relationships
____ Romantic Relationship (s) (if applicable)
____ Friendships
____ Parenting Abilities (if applicable)
____ Work/School Relationships

____ Job Satisfaction
____ Job Functioning

____ School Satisfaction
____ School Functioning

____ Self-Esteem
____ Outlook on the Future

____ Ability to Cope with Stress

Do you consider yourself to be a spiritual or religious person? ___ No ___ Yes

If yes, please describe your faith or belief: _____

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish during your time in therapy?

Any other additional information you would like the therapist to know?

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