Cornerstones Counseling Center
INTAKE FORM

Please note: Information you provide here is protected and confidential information.

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

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years old)

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Identified Gender: _____

Identified Cultural Background: _____

Veteran Status: ☐ Yes ☐ No Branch of Service: _____

Disability: ☐ Yes ☐ No How does this impact you?_____

Marital Status:
☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Long-term Partnership

Please list any children/ages/relationship to self/partner:

_____ _____

Address: _____
(Street and House Number) (Apt/Unit)

_____
(City) (State) (Zip code)
Home Phone: ( ) May we leave a message? ☐ Yes ☐ No
Cell/Other: ( ) May we leave a message? ☐ Yes ☐ No

Email: _____
May we email you? ☐ Yes ☐ No
*Please Note: Email correspondence is not considered to be a confidential mode of communication.

Date: _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalizations, etc.)? ? ☐ Yes ☐ No

If Yes, Previous Providers: _____

Are you currently taking any prescription medication? ☐ Yes ☐ No
Please List: _____

Have you ever been prescribed psychiatric mediation? ☐ Yes ☐ No
Please list medication, dates and description of need:

_____

_____

General Health and Mental Information

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with you appetite or eating patterns:

_____

_____

5. Are you currently experiencing overwhelming grief, sadness or depression?
   ☐ Yes ☐ No
   If yes, for approximately how long have you felt this way? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
   ☐ Yes ☐ No
   If yes, when did you begin experiencing this? _____

7. Are you currently experiencing chronic pain?
   ☐ Yes ☐ No
   If yes, please describe _____
8. How often do you consume alcohol?
   ☐ Daily ☐ Weekly ☐ Monthly
   ☐ Infrequent/Casually ☐ Never
9. How often do you engage in recreational drug use?
   ☐ Daily ☐ Weekly ☐ Monthly
   ☐ Infrequent/Casually ☐ Never
10. Are you currently in a romantic relationship?
    ☐ Yes ☐ No
    If yes, for how long? _____

    What level of commitment do you maintain in this relationship?

    On a scale of (low)1-10 (high), how important is this relationship to you?
    _____
    On a scale of (low)1-10 (high), how would you rate your satisfaction in this relationship? _____
11. What, if any, significant life changes or stressful events have you experienced recently? What role, if any, do these play in your seeking therapy?
    _____
    _____
    _____
    _____

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ie. Self & Father, grandmother, uncle, etc.).

	Circle One	Family Member_____
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Physical Disability	yes/no	
Developmental Disability	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Self-Harm	yes/no	

Additional Information:

1. Are you currently employed? ☐ Yes ☐ No

If yes, where are you employed? _____
Title: _____
How many hours per week do you work? _____

If you are employed, do you enjoy your work? In what ways does your work impact your life?

_____
_____

2. Are you currently in school? ☐ Yes ☐ No

If yes, where are you in school? _____
Area of Study: _____

If you are in school, in what ways does your school life impact your personal life?

_____
_____

3. Do you consider yourself to be spiritual/religious? ☐ Yes ☐ No
If yes, briefly describe your faith or belief system:

Of what importance is your chosen faith or belief system to you? _____

4. What do you consider to be some of your strengths?

5. What do you consider to be areas of growth, learning, and current struggles for you?

6. What do you most want to work on in therapy?

7. What would you most like to accomplish through participating in therapy?

8. Have you attended therapy in the past? What went well/didn't go well for you?

Signature _____ Date_____