Stacy Smith Counseling LLC

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INTAKE FORM

General Information

Name: ___________________________________ Date of Birth: __________________________________
Address: ____
City: ____ State: _________________ Zip: _______________
Home Phone #: _______________________________ Cell Phone #: ________________________________
Ok to leave phone messages? Yes No Which number? __________________________________
Ok to reach me by E-mail?* Yes No E-Mail: ____
Ok to reach me via text message?* Yes No

*I fully understand that Email and text message communication is ***NOT*** considered secure. By circling "yes" above, I give Stacy Smith permission to use these methods for scheduling of appointments, including sending out appointment reminders.

Therapy Goals

What is the reason for coming to therapy today? ____
____
____
____
____
____
____

Treatment History

Have you ever seen a therapist before? YES NO
If yes, did you seek treatment for similar concerns you are presenting with today? If no, please explain:
____
____

What helped? ____
What didn't? ____

Have you ever seen a psychiatrist in the past? YES NO Currently? YES NO
Current medications and supplements, along with dosage and prescriber: ___________________________
____
____

Medical conditions: ____

When was your last physical exam? ____

Have you ever been hospitalized for emotional, psychological, or substance use issues? YES NO
If yes, when and for how long: ____
Location/Facility Name: ____

Family History

Who currently lives with you? ____
____
____

Is there a family history of any of the following conditions? If so, please explain.

Learning Disability: ____
Depression/Bipolar Disorder: ____
Alcoholism/Drug Addiction: ____
Anxiety/Panic Attacks: ____
Trauma (Combat, abuse, sexual assault, etc.): ____
Suicide Attempts: ____
Eating Disorders (Anorexia/Bulimia): ____
Hyperactivity/ADHD: ____
Psychosis: ____
Other Problems: ____

Substance Use

Do you have a history of substance use/abuse? YES NO Are you currently using? YES NO
If yes to either of the above, what is/was your substance of choice? _________________________________
Frequency of use? ____
Have you ever been in treatment specifically for substance use? YES NO
If yes, what kind of treatment, and for how long? ____

Social Functioning

How would you describe your current social experiences? ____
____
____
____

Academic/Work Functioning

Are you currently in school? YES NO
If yes, how would you describe your academic performance and overall functioning in the school environment? ____
____
____
____

Are you currently working? YES NO
If yes, what is your occupation, and how would you describe your overall functioning in the work environment? ____
____
____
____

Risk Assessment

Have you ever had thoughts of wanting to end your own life? YES NO
If yes, please explain: ____
____

Have you ever acted on these thoughts? YES NO
If yes, please explain: ____
____

Are there weapons in your home? YES NO

General Coping

What are your strengths? ____
____
____

What are some healthy (and unhealthy) coping skills you generally use? ______________________
____
____

Additional Information

What additional information do you feel would be helpful for me to know? ____________________
____
____
____
____
____
____
____
____
____

My signature below indicates that I, ______________________________, have completed the above questions as completely and accurately as possible.

____
Name (print) Signature Date