Ted Greenblatt Counseling

INTAKE FORM

Initial Appt Date:

Date: _____

Name: _____ Gender: _____ Age: _____

Race/Ethnicity (optional) _____

Local Address: _____ City: _____ ZIP: _____
Can you receive confidential mail here? (Y/N) _____
If no, where can you receive confidential mail? _____

May I contact you by email for scheduling purposes? (Y/N) _____ Address: _____
Email is not a confidential form of communication

Local Phone: _____ May I call you here? (Y/N) _____ May I leave a message? (Y/N) _____
Cell Phone: _____ May I call you here? (Y/N) _____ May I leave a message? (Y/N) _____
How did you hear about me? _____
Who, if anyone, has urged you to come here? _____

Briefly tell me about the concerns that have brought you here. _____

Please check any current or past issues that still affect you.

__ Eating disorders
__ Academic issues
__ Childhood abuse (e.g., physical, sexual, emotional)
__ Stress / anxiety
__ Phobias (type: _____)
__ Alcohol/other drug use
__ Sexual assault / rape
  __ recently (when? _____)
  __ in the past
__ Death of someone close
  __ recently (when? _____)
  __ in the past
__ Addictions (type:_____)
__ Family issues (e.g.., divorce, alcoholism, domestic violence)
__ Other: _____
__ Pregnancy issues
__ Spiritual concerns
__ Depression
__ Pornography
__ Sexual identity issues
__ Relationship concerns
  __ family
  __ friend
  __ parent
  __ significant other
  __ roommate
  __ other: _____
__ Financial issues
__ Suicidal thoughts

Your History

Current medical problems: _____
List all current medications, including herbal, and how long you have been on them. _____

Have you been on any medications in the past for mental health issues? _____
Please list: _____

Have you previously seen a therapist? _____ Who? _____ When? _____
Where? _____ For what types of issues? _____

Are you currently seeing a therapist? _____ Who? _____ When? _____
Where? _____ For what types of issues? _____

Have you ever been hospitalized for physical or mental health issues? _____ Briefly describe: _____
_____

Have you had any previous suicide attempts? _____ Briefly describe: _____
_____

Does anyone in your family have a history of mental/physical health issues? Who? What type? _____
_____

If you currently experience any of the following, please rate them using the key below:

0 = Never 1 = Seldom 2 = Often 3 = Always

___ Difficulty concentrating
___ Crying
___ Missing classes/work
___ Feeling helpless
___ Feeling uptight
___ Worrying
___ Feeling hopeless
___ Feeling afraid
___ Lying to others
___ Feeling out of control
___ Feelings of self-doubt
___ Injuring self (How: _____)
___ Nervous around others
___ Stealing or legal problems
___ Memory loss or blackout
___ Difficulty sleeping (too much or too little)
___ Suicidal thoughts

___ Anger
___ Negative thoughts about body
___ Relationship issues
___ Feelings of isolation
___ Lack of energy
___ Meaninglessness
___ Impulse control
___ Drinking heavily
___ Other drug use
___ Guilt feelings
___ Withdrawing socially
___ Sexual preoccupation
___ Physical symptoms (e.g.., headaches, digestive)
List: _____
_____
Have you seen a health care provider for these?___
___ Other: _____

Are you interested in a counseling group? _____ For what issues/topics? _____