HOPE AND HARMONY COUNSELING, Ltd.
CLIENT CONTACT FORM

***Please provide the following information and answer the questions below. Please note the information you provide here is protected by client/therapist confidentiality.***

**Client Contact Information:**

Name:

_____

(Last) (First) (Middle Initial)

Address:

_____

(Address) (City) (State, Zip)

Home Phone number: _____May we leave a message? YES / NO
Cell Phone number: _____May we leave a message? YES / NO
Work Phone number: _____May we leave a message? YES / NO
Home/Work number: _____May we leave a msg with 3rd party? YES / NO
Email address:_____
May we communicate by email?* YES / NO

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

Additional way to be contacted:_____

Referred by:_____

**Emergency Contact Information:** (Who should we contact in case of an emergency?)

Name:_____ Relationship to you:_____
Cell Phone number:_____ Home Phone number: _____
Other relevant contact info:_____

**Please write any additional emergency contact information on the back of this sheet.*

**Physician Contact Information:**

Name of Physician:_____ Phone Number:_____
Associated Hospital:_____
May we contact your physician: (Please note: Release of Information form must be signed) YES / NO

**Please write any additional physician contact information on the back of this sheet.*

**Other Important Contact Information: (**If you are under the care of a psychiatrist, reiki specialist, homeopath or other, please provide the contact information below.)

Name of Professional:_____ Phone Number:_____
May we contact this person: (Please note: Release of Information form must be signed) YES / NO

**Please write any additional other important contact information on the back of this sheet.*

HOPE AND HARMONY COUNSELING, Ltd.
ADULT INTAKE FORM

*Please provide the following information and answer briefly the questions below. This information will be discussed in depth during Intake. Please note: Information you provide here is protected as confidential.*

**BRIEFLY DESCRIBE YOUR REASON FOR SEEKING COUNSELING:**

_____

_____

_____

**PHYSICAL AND MENTAL HEALTH:**

**1.** How would you rate your **current physical health**? (*please circle*)

Poor----------Unsatisfactory----------Satisfactory----------Good----------Very Good

**2.** How would you rate your **current mental health**? (*please circle*)

Poor----------Unsatisfactory----------Satisfactory----------Good----------Very Good

**3.** Please check off any difficulties you are currently experiencing:

| | | |
|---|---|---|
| **____Grief/Loss** | **____Chronic Medical Problems** | **____Employment Issues** |
| **____Parenting Issues** | **____Legal/Financial Problems** | **____Relationship Issues** |
| **____Family Related Issues** | **____Religious/Spiritual Issues** | **____Sexual/Intimacy Issues** |
| **____Anxiety/Depression** | **____Communication/Trust Issues** | **____Combat Related Issues** |

**____Other (Please Explain):** _____

**4.** Have you previously received mental health services for these or other conditions? Yes / No

If yes, please indicate dates, whether inpatient/outpatient, issues for which you were treated.

_____

**5.** Are you currently taking any prescribed medication (psychiatric or other)? Yes / No

If yes, please list current medications and dosage:

_____

**6.** If not on medication, is a referral for a medication evaluation needed? Yes / No

**SELF CARE:**

**1.** What kinds of things do you do currently to take care of yourself?

_____

**2.** How would you describe your diet? _____

**3.** What activities do you enjoy? _____

**4.** Is there anything additional that you would like me to know regarding your personal self-care that may help in therapy? _____

_____

HOPE AND HARMONY COUNSELING, Ltd.
ADULT INTAKE FORM

**FAMILY MENTAL HEALTH:**

*Please indicate if there is a family history of any of the following. If yes, please indicate which family member(s) and briefly how it has affected you.*

Abuse: ☐**Yes** ☐ **No**_____

Alcohol: ☐**Yes** ☐ **No**_____

Anxiety: ☐**Yes** ☐ **No** _____

ADD(H): ☐**Yes** ☐ **No** _____

Bipolar: ☐**Yes** ☐ **No** _____

Depression: ☐**Yes** ☐ **No** _____

Domestic Violence: ☐**Yes** ☐ **No** _____

Eating Disorder: ☐**Yes** ☐ **No** _____

Obesity: ☐**Yes** ☐ **No** _____

Obsessive Compulsive Behavior: ☐**Yes** ☐ **No** _____

Post-Traumatic Stress: ☐**Yes** ☐ **No** _____

Schizophrenia: ☐**Yes** ☐ **No** _____

Substance abuse: ☐**Yes** ☐ **No** _____

Suicide Attempt(s): ☐**Yes** ☐ **No**_____

**SOCIOCULTURAL BACKGROUND:**

**1.** Are you currently employed? Yes / No

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**2.** Do you consider yourself financially secure? Yes / No

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**3.** How do you identify yourself spiritually/religiously_____

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**4.** How do you identify yourself with respect to your sexual orientation, gender identity, or gender expression?

_____

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**5.** Relationship Status: (*mark all that apply*)

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Casual ☐ Committed

**6.** Do you have children? Yes / No

If yes, how many and what ages?

_____

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**7.** How do you identify yourself ethnically/culturally?_____

Is there anything additional that you would like me to know regarding this that may help in therapy?

_____

**8.** Is there any additional information regarding yourself or your family that may be helpful for me to know?

_____

_____

**OTHER:**

**1.** Describe your most supportive relationship (past and/or present):

_____

_____

**2.** Reflecting on past experiences, what is an example of something you have overcome and how did you do it?

_____

_____

**3.** What did you learn about yourself from this experience?

_____

_____

**4.** What would you like to accomplish from coming to therapy?

_____

_____

**5.** List at least three personal characteristics you consider strengths:

_____

_____

Client Signature_____ Date_____