THE COMPASS CENTER FOR WELLNESS, PLLC
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INTAKE FORM

Please complete this form and bring it to your first session.

Client Name: ____________________________________ Date of Birth: ____________________________________

Street Address: ____________________________________ Cell Phone: ______________________________________

City, State, Zip: ____________________________________ Other Phone: ____________________________________

Email Address: ____________________________________

Marital Status: Married (# of years): _______ Single: ________ Separated (since): ________ Divorced (since): _________

Education (last year completed): ________________________ Degree(s): ____

Client's Occupation: __________________________________ Employed by: ___________________________________

Please list all members of your household:

	Name – Relationship	Birth Date – Age	Gender
1.	___________________________	_________________________	____________________
2.	___________________________	_________________________	____________________
3.	___________________________	_________________________	____________________
4.	___________________________	_________________________	____________________
5.	___________________________	_________________________	____________________

Medical Information

Name of Primary Care Physician: ____________________________ Phone #: ___________________________

List any medical conditions: ________________________________

Are you currently on any medications? YES ______ NO ______

If so, please identify medication, dosages and times taken: ____

Emergency Contact Information

1. Name / Phone #: ___________________________________ Relationship: ________________________

2. Name / Phone #: ___________________________________ Relationship: ________________________

*Do these people know you are in therapy? 1. YES _____ NO ______ 2 YES ______ NO ______

Legal Information

Are there any legal cases pending? YES _____ NO _____

Briefly describe the nature of those cases: ____

Spiritual Information

Do you consider yourself a Christian? YES _____ NO _____

My relationship with God is: ____

Do you desire prayer and/or Bible reading to be part of your counseling: YES _____ NO _____

Church denomination? ____________________________ What church do you attend?_____________________

How often do you attend worship services? _______________

Alcohol / Drug History

1. Do you drink alcoholic beverages? Yes _____ No _____ Maybe _____
2. Have you or a family member ever been concerned about your alcohol usage? Yes _____ No _____ Maybe _____
3. Have you ever been concerned about another family members' usage? Yes _____ No _____ Maybe _____
4. Do you have a history of illegal drug use or prescription abuse? Yes _____ No _____ Maybe _____
5. Do you smoke cigarettes or other tobacco products? Yes _____ No _____ Maybe _____
6. Have you or a family member ever been concerned about your illegal drug use or prescription drug abuse?
Yes _____ No _____ Maybe _____
7. Have you ever been concerned about another family members' illegal drug use or prescription drug abuse? Yes _____ No _____
Maybe _____

Symptom History (Please Check)

__Aggression __Appetite change __Sleeping problems __Racing thoughts
__Fatigue __Grief __Distractibility __Nightmares
__Judgment errors __Memory difficulties __Indecisiveness __Low self-worth
__Phobias/fears __Sadness __Panic attacks __Impulsivity
__Alcohol dependence __Avoiding people __Social problems __Disruptive thoughts
__Feeling anxious __Hopelessness __Drug dependence __Anger
__Loneliness __Mood shifts __Irritability Periods of crying __Feelings on edge
__Pornography __Sexual addiction __Withdrawing

Briefly describe how the above symptoms impact your ability to function: _____________________________________

Briefly describe any unusual or traumatic circumstances in your history: ____

Counseling Details

Briefly describe your current difficulty: How long has the problem existed? _____________________________________

____

____

____

____

What attempts have been made to resolve the difficulties? ____

____

____

____

____

What are the goals you hope to achieve through counseling? ____

____

____

____

Have you been to counseling before? YES _____ NO_____

Support/Recovery Groups? YES _____ NO ______

If yes, identify counselor and the dates: ____

Briefly explain the nature and outcome of that counseling: ____

I agree that the information I have provided is accurate and true, to the best of my ability.

Client Signature: ____ Date: _______________