Counseling and Health Center, LLP
Intake Information

Name_____ **Date of Birth**_____

Briefly describe reason for seeking help:_____

_____

_____

_____

_____

Name of Physician:_____ **Last Visit**_____

Major Health Problems:_____

_____

Current Medications:_____

_____

Previous Psychotherapy or Counseling:_____

_____

Circle any of the following which are a problem for you:

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol	Unhappiness
Anger	Self-Control	Work	Sleep
Stress	Tiredness	Memory	Legal Matters
Ambition	Energy	Insomnia	Decision-Making
Loneliness	Self-Esteem	Education	Concentration
Temper	Nightmares	Marriage	Children
Appetite	Stomach Troubles	Parenting	My thoughts