

COUNSELING INTAKE FORM

Date: _____

Client's Name _____ Date of Birth: _____ Social Security _____

Marital Status: Single ___ Engaged ___ Married ___ Divorced ___ Widowed ___ Separated ___ Date: _____

Race: _____ Ethnicity: _____ Nationality: _____

Country(Nation) of Citizenship: _____

Parent / Guardian's Name (*minor clients*) _____ Partner's Name: _____

Additional Family Members & Ages: _____

Home Address: _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Leave Message at Home? Yes ___ No ___ Prefer Text Message? Yes ___ No ___

In Case of Emergency Contact Name/Phone Number: _____

E-mail Address _____ Website _____

Employer's Name _____ Address _____

Job Title _____ Length of time employed by this employer _____

Referred by: _____ Phone: _____

Religious Background: _____

Church: _____ Address: _____

Pastor: _____ Phone: _____

Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Attorney: _____ Phone: _____

Probation Officer: _____ Phone: _____

Highest Level of Education: _____ Major _____

Schools graduated from _____

Insurance Company: _____ Policy Number: _____

Have you ever filed for bankruptcy? Yes ___ No ___ Have you ever been involved in a lawsuit? Yes ___ No ___

Have you ever been incarcerated? Yes ___ No ___ Have you ever had an abortion? Yes ___ No ___

Have you ever been in a relationship with someone who has had an abortion? Yes ___ No ___

What was your relationship with them? _____

Current Weight: _____ Height: _____ Eyes: _____ Hair: _____ Handedness: Right ___ Left ___

Tattoos, body modifications, piercings: _____

Disabilities: Type: _____ Degree of: _____

Type: _____ Degree of: _____

Previous Therapy? Yes ___ No ___ Former Therapist: _____

Describe the benefit of your previous therapy _____

Military History including MOS: _____

Type of Military Discharge: _____

CONSENT TO COUNSELING

I, the undersigned, am requesting counseling and / or consultation services by

Harry L. Morgan, M.Div., Th.M., M.A., Ph.D., LMHC, CCFMHE

This authorizes Dr. Morgan to provide psychotherapy, mental health testing, consultation and referral services. I have been informed of the nature and purposes of this service, and that my consent can be revoked in writing prior to, and/or during any of these services rendered.

I have read and fully understand the above authorization for counseling/consultation. No guarantee or assurance has been made to me as to any of the results that may be obtained from these services. This is a release of any and all liability to Dr. Morgan and the staff of Clinical & Forensic Mental Health Services of any decisions or actions that I may or may not take as a result of the services I receive at this Center.

I give consent to release the information provided during my therapeutic evaluation and counseling sessions for the duration of my counseling to be shared with Dr. Ronald Aung-Din, Neuropsychiatrist who is his associate when appropriate.

Furthermore, I have received a copy of the Licensed Mental Health Counselor Client Services Agreement in compliance with HIPAA.

Client's Signature: _____

Signature of Parent or Guardian if client is under 18 _____

Staff Signature: _____

Date: _____

MEDICAL HISTORY Please check (✓) physical, neurological and behavioral conditions you have.

General Physical	Neurological	Behavioral
<input type="checkbox"/> Abortion (<i>my own or my partner</i>)	<input type="checkbox"/> Amnesia	<input type="checkbox"/> Alcohol Consumption (<i>description _____</i>) (<i>amount per week _____</i>)
<input type="checkbox"/> Allergies	<input type="checkbox"/> Autism	<input type="checkbox"/> Weight Gain / Loss (circle which) (<i>description _____</i>)
<input type="checkbox"/> Bowel/Bladder	<input type="checkbox"/> Blackouts	<input type="checkbox"/> ADD / ADHD
<input type="checkbox"/> Cancer	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Alcohol Consumption
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> Appetite Changes
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Bulimia / Anorexia (circle which)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Concussion	<input type="checkbox"/> Change in Sexual Drive
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Compulsive Sexual Activity
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Electro-Shock Therapy	<input type="checkbox"/> Constant Hunger
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Episodic Disorientation	<input type="checkbox"/> Déjà vu
<input type="checkbox"/> Menstrual Irregularities	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Food Cravings
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Heat/cold sensitivity
<input type="checkbox"/> Problems Walking	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Impotence
<input type="checkbox"/> Rashes	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Thyroid Dysfunction	<input type="checkbox"/> Neuropathic Pain	<input type="checkbox"/> OCD
<input type="checkbox"/> Tremors	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Personality Change
<input type="checkbox"/> Unusual Hair Loss	<input type="checkbox"/> Seizures (including epilepsy)	<input type="checkbox"/> Physical Change
<input type="checkbox"/> Urinary / Kidney Problems	<input type="checkbox"/> Sensory Distortion	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Visual Problems	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tobacco Usage (<i>Amount per week _____</i>)
<input type="checkbox"/> Weakness	<input type="checkbox"/> Tourette's Syndrome	

List all prescription and over-the-counter medications:

Prescription Medication	Dosage	Prescription Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all non-prescription, over-the-counter medications and vitamin/mineral therapies:

Non-Prescription Medication	Dosage	Non-Prescription Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSONAL HISTORY / PROBLEM EVALUATION BASIC PROBLEM IDENTIFICATION

Please check any of the follow symptoms or conditions you have had or are now experiencing.

<u>CONDITION:</u>	PAST <small>More than 6 months</small>	PRESENT <small>Less than 6 months</small>	<u>CONDITION:</u>	PAST <small>More than 6 months</small>	PRESENT <small>Less than 6 months</small>
Mood high & lows	_____	_____	Physical abuse from others	_____	_____
Irritability	_____	_____	Sexual abuse from others	_____	_____
Excessive stress	_____	_____	Excessive worries	_____	_____
Crying spells	_____	_____	Difficulty concentrating	_____	_____
Phobias or fears	_____	_____	Hearing unseen voices	_____	_____
Confusion	_____	_____	Frequent loss of temper	_____	_____
Low self-esteem	_____	_____	Acting out violence	_____	_____
Compulsive behaviors	_____	_____	Frequent residence changes	_____	_____
Depression	_____	_____	Frequent employment change	_____	_____
Extreme nervousness	_____	_____	Bed wetting past age 6	_____	_____
Lack of Motivation	_____	_____	Fire setting past age 6	_____	_____
Indecisiveness	_____	_____	Blaming others frequently	_____	_____
Loss of memory	_____	_____	Lack of sexual desire	_____	_____
Fantasizing	_____	_____	Compulsive Sexual Activity	_____	_____
Use of pornography	_____	_____	Spiritual confusion	_____	_____
Physical abuse of children	_____	_____	Thoughts of suicide	_____	_____
Sexual abuse of children	_____	_____	Difficulty reading	_____	_____
Physical abuse of others	_____	_____	Inability to comprehend math	_____	_____
Excessive sexual activity	_____	_____	Inability to express yourself	_____	_____
			Involvement with the occult	_____	_____

1. When (approximately) did you have a complete physical examination? _____ Where? _____

2. What physical disorders do you have, if any?

3. Describe your current relationship to God.

BACKGROUND INFORMATION

(Briefly Answer the Following)

1. Identify and describe the problem as best as you can.

2. What have you done to resolve the problem?

3. What are you seeking from this counseling?

4. What immediate circumstances have led to your making this appointment?

5. What additional information do you think would be helpful to the counselor?
