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

CONDITION:	**PAST** More than 6 months	**PRESENT** Less than 6 months	**CONDITION**:	**PAST** More than 6 months	**PRESENT** Less than 6 months
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?