HART COUNSELING SERVICES, PLLC

15901 Central Commerce Dr. Ste # 506
Pflugerville, TX 78660
Phone: (512) 518-1920 ❤ Fax: (512) 777-2982

Counseling Intake Form

Please complete this form as best you can. This information is confidential and is designed to help me learn a little more about you and help our time together be as productive as possible.

Client Information

Today's date: _____

First and Last Name: _____

Preferred name: _____

Date of Birth: _____

How do you describe your gender identity? _____

Preferred gender pronoun (ex: he, him, she, her, all pronouns)? _____

How do you describe your sexual orientation? _____

How do you describe your racial/ethnic heritage? _____

How can I reach you?

Best Contact number: _____

Can I call you? Yes / No

Leave a message? Yes / No

Texting - **limited to emergency scheduling issues only** -Yes / No

Can I email you? Yes / No

Email Address: _____

Employer/occupation: _____

Residence Address: _____ City/Zip: _____

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Marital Status

Married / Separated / Divorced / Partnered / Single

How long? _____

Spouse/Partner's name: _____

Spouse/Partner's age: _____

Children: Yes / No

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Presenting Concern

Briefly tell me what brings you in today?

_____

_____

_____

_____

How have you managed this concern up to this point?

_____

_____

_____

_____

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In what way do you hope, as your counselor, I can help you?

_____

_____

_____

_____

When was the last time you had a good belly laugh?

_____

_____

_____

_____

Background information:

Family Relationships

Father's Name: _____ Age: ____ (Living or Deceased)

Mother's Name: _____ Age: ____ (Living or Deceased)

Siblings: Yes / No

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

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Other Siblings, Significant Persons and/or Relationships:

_____

_____

_____

_____

_____

Health Related Concerns

Rate your health: Very Good __ Good __ Average __ Declining __ Poor __

Major Illness (Past or Present):

_____

_____

_____

Surgeries: _____

Injuries: _____

Have you ever received any type of mental health services? Yes / No

If yes, what type: (check all that apply)

___ Therapy - group/individual

___ Medication

___ Inpatient Hospitalization

Briefly describe what the experience was like for you? What did you like/not like?

_____

_____

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Have you ever received a psychiatric diagnosis? Yes / No

If yes, please name the diagnoses and/or any current medications:

_____

_____

_____

Substance Use History

Do you have an addiction? Yes ____ No ____ Uncertain ____

Have you used drugs for reasons other than medical purposes? Yes/No

When? _____

What? _____

Frequency/Amount: _____

Do you drink alcoholic beverages? Yes/No

Frequency: _____

Is there anything else you want me to know?

_____

_____

_____

_____

_____

If applicable:
How did you find me? Referral source: _____

Thank you for completing this form. Please allow me a few moments to review it and then we can get started. - Jenn