

HART COUNSELING SERVICES, PLLC

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Pflugerville, TX 78660
Phone: (512) 431-4558 Fax: (512) 777-2982

Counseling Intake Form

Client Information

Full Name: _____

Preferred name: _____ Date of Birth: _____

Residence Address: _____

City/Zip: _____ May I send you mail? Yes ___ No ___

Best Contact number: _____ Can I call you? Yes ___ No ___

Leave a message? Yes ___ No ___ Texting - **limited to scheduling and educational links only** - Yes ___ No ___ Can I email you? Yes ___ No ___

Email Address: _____

Employer/occupation: _____

Are there any limits on contacting you that you wish for me to know? _____

How do you describe your gender identity? _____

How do you describe your sexual orientation? _____

How do you describe your racial/ethnic heritage? _____

Married ___ Separated ___ Divorced ___ Partnered ___ Single How long? _____

Spouse/Partner's name and age: _____

Children: Yes ___ No ___

Name	Age	Name	Age
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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Emergency Contact

In the event there is an emergency during my care please contact the following person:

Name: _____ (printed) Relationship: _____

Phone Number: _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Significant Persons and/or Relationships:

Health Related Concerns

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

Anything you'd like for me to know about your overall health?

Major Illness (Past or Present):

Surgeries: _____

Injuries: _____

Substance Use History

Do you have concerns about addiction? Yes ____ No ____ Uncertain ____

Do you have concerns about substance use/abuse? Yes ____ No ____ Uncertain ____

Do others in your life have concerns about possible addictive and/or use/abuse issues within your life? Yes ____ No ____ Uncertain ____

How would you describe your use of alcohol and/or drugs?

Please read through the following list let me know what concerns you're having or have had that you want me to know about. In front of each concern that applies, please rate the level to which you find, or found it distressing:

1 (Mild)	2 (Moderate)	3 (Serious)	4 (Severe)	5 (Very Severe)
<input type="checkbox"/> Relational stress	<input type="checkbox"/>	<input type="checkbox"/> General physical pain	<input type="checkbox"/>	<input type="checkbox"/> Problems controlling anger/urges
<input type="checkbox"/> Family conflict/violence	<input type="checkbox"/>	<input type="checkbox"/> Hot or cold spells	<input type="checkbox"/>	<input type="checkbox"/> Very talkative
<input type="checkbox"/> Divorce	<input type="checkbox"/>	<input type="checkbox"/> Memory problems	<input type="checkbox"/>	<input type="checkbox"/> Drawing away from people
<input type="checkbox"/> Parenting concerns	<input type="checkbox"/>	<input type="checkbox"/> Sweating	<input type="checkbox"/>	<input type="checkbox"/> Emotional Issues
<input type="checkbox"/> Behavioral problems of child	<input type="checkbox"/>	<input type="checkbox"/> Lightheaded / dizzy	<input type="checkbox"/>	<input type="checkbox"/> Feeling worthless/hopeless
<input type="checkbox"/> Runaway child	<input type="checkbox"/>	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/> Worry / anxiety
<input type="checkbox"/> Child needs shelter	<input type="checkbox"/>	<input type="checkbox"/> Loss of weight	<input type="checkbox"/>	<input type="checkbox"/> Fear
<input type="checkbox"/> Hard to make friends	<input type="checkbox"/>	<input type="checkbox"/> Gain of weight	<input type="checkbox"/>	<input type="checkbox"/> Nervous / tense
<input type="checkbox"/> Hard to trust anyone	<input type="checkbox"/>	<input type="checkbox"/> Upset stomach	<input type="checkbox"/>	<input type="checkbox"/> Shame
<input type="checkbox"/> Feel used by people	<input type="checkbox"/>	<input type="checkbox"/> Shaky / trembling	<input type="checkbox"/>	<input type="checkbox"/> Sad / depressed
<input type="checkbox"/> Other relationship issues	<input type="checkbox"/>	<input type="checkbox"/> Sleep problems / nightmares	<input type="checkbox"/>	<input type="checkbox"/> Resentment
<input type="checkbox"/> Sexual problems	<input type="checkbox"/>	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/> Anger / frustration
<input type="checkbox"/> Sexual abuse issues	<input type="checkbox"/>	<input type="checkbox"/> PMS symptoms	<input type="checkbox"/>	<input type="checkbox"/> Confusion
<input type="checkbox"/> Sexual offender	<input type="checkbox"/>	<input type="checkbox"/> Drugs / alcohol	<input type="checkbox"/>	<input type="checkbox"/> Loneliness / abandonment
<input type="checkbox"/> Sexual identity questions	<input type="checkbox"/>	<input type="checkbox"/> See/hear strange things	<input type="checkbox"/>	<input type="checkbox"/> Guilt
<input type="checkbox"/> Gender identity questions	<input type="checkbox"/>	<input type="checkbox"/> Quick change of moods	<input type="checkbox"/>	<input type="checkbox"/> Jealousy
<input type="checkbox"/> Physical abuse	<input type="checkbox"/>	<input type="checkbox"/> Unwelcome thoughts	<input type="checkbox"/>	<input type="checkbox"/> Feel ignored
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Feeling others are out to get me/being watched/talked about	<input type="checkbox"/>	<input type="checkbox"/> Feel suicidal
<input type="checkbox"/> Health / physical / illness	<input type="checkbox"/>	<input type="checkbox"/> Panicky	<input type="checkbox"/>	<input type="checkbox"/> Dwelling on problems
<input type="checkbox"/> Less energy than usual	<input type="checkbox"/>	<input type="checkbox"/> Financial problems	<input type="checkbox"/>	<input type="checkbox"/> Lack of interest / enjoyment
<input type="checkbox"/> More energy than usual	<input type="checkbox"/>	<input type="checkbox"/> Legal problems	<input type="checkbox"/>	<input type="checkbox"/> Grief / loss
<input type="checkbox"/> Restless / can't sit still	<input type="checkbox"/>	<input type="checkbox"/> Difficulty staying focused	<input type="checkbox"/>	<input type="checkbox"/> Faith / spiritual issues
<input type="checkbox"/> Problems with my breathing	<input type="checkbox"/>			
<input type="checkbox"/> Other:				

Mental Health Service History

Have you received any prior mental health services? (check all that apply)

- Support Group Therapy (group individual couple's)
- Medication Inpatient Hospitalization Intensive Outpatient Services

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

Have you had a mental health diagnosis?

If yes, what is/are the diagnosis/es, medications your taking related to the diagnosis, and, what are your thoughts about the diagnosis?

Do you have concerns or questions about a current, past, or possible diagnosis you'd like to discuss with me? Yes ___ No ___ Uncertain ___

Presenting Concern

Briefly, tell me what brings you to therapy, and what led you to believe this concern was worth exploring in therapy at this time?

How have you managed this concern up to this point? Has anything in particular been helpful?

In what ways do you hope I, as your therapist, can help you?

Referring to the table on the prior page, and the concerns you identified there – please use this space to further explain anything you want me to be aware of that's especially concerning today:

Is there anything else you want me to know?

If applicable:

How did you find me? Referral source: _____

If this person is another professional, may I thank them for the referral? Yes ___ No ___