**DM COUNSELING LLC INTAKE FORM**

**Confidential Client Information**

Name Date

Date of Birth Age Gender: [ ] Male [ ] Female

Address City/State/Zip

Home Phone # Ok to leave message? [ ] Yes [ ] No

Work or Cell # Ok to leave message? [ ] Yes [ ] No

Text Message OK to confirm sessions? [ ] Yes [ ] No

Text Message OK to confirm sessions? [ ] Yes [ ] No

Email Address

Spouse’s Name

Marital Status: [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Single

Children’s Names and Ages

Emergency Contact Relationship to You

Home Phone # Work or Cell #

Employer

Employer Address

How did you hear about me?

Primary Care Physician Phone

Address

Current Medical Problems

Current Medications

**Check Any Additional Conditions You Have Had:**

[ ] ADD/ADHD [ ] Chronic Fatigue [ ] Hypoglycemia [ ] AIDS/HIV

[ ] Chronic Pain [ ] Learning Disability [ ] Alcohol Abuse [ ] Depression

[ ] Migraines [ ] Allergies [ ] Diabetes [ ] Obesity

[ ] Anemia [ ] Drug Abuse [ ] OCD [ ] Anger Problems

[ ] Epilepsy [ ] Panic Attacks [ ] Anxiety/Phobias [ ] PTSD

[ ] Fibromyalgia [ ] Skin Problems [ ] Arthritis [ ] Head Trauma

[ ] Stomach Ulcers [ ] Asthma [ ] Heart Disease [ ] Suicide Attempt

[ ] Autism [ ] High Blood Pressure [ ] Thyroid Problems [ ] Cancer

[ ] High Chronic Stress Other:

Have you served in the military? [ ] Yes [ ] No Combat? [ ] Yes [ ] No

Have you ever had previous psychiatric care or counseling? [ ] Yes [ ] No

Name of Psychiatrists or Counselors

Reasons for seeking help:

Was previous psychiatric care or counseling helpful? [ ] Yes [ ] No

Church or Religious Affiliation

**PRIMARY INSURANCE:** **SECONDARY INSURANCE:**

[ ] No Insurance Coverage

Name Name

Address Address

Phone # Phone #

Client ID# Client ID #

Group/Plan# Group/Plan#

Policy Holder Name Policy Holder Name

Date of Birth Date of Birth

Relationship to You Relationship to You

**PERSONAL GOALS FOR COUNSELING**

Please List the Primary Concerns You Want to Discuss in Therapy and the Specific Goals You Wish to Accomplish:

Presently, from your perspective, what is the greatest concern in your life/family?

How do you contribute or participate in this present concern?

If you could change one thing about your life/family.......what would it be?

State one thing you most admire about your spouse, significant other, parents, siblings, and child or children:

State one area your family needs to work on and improve:

When you are facing problems (presently what does your mother do) or when there were problems (when growing up at home) your mother did what?

When you are facing problems (presently what does your father do) or when there were problems (when growing up at home) your father did what?

If you could do anything you wanted today.........what would you do?

How would this make you feel?