Inner Peace Counseling Services

Individual, Couples and Family Therapy

Client Intake Information

Name: _____ **Date:** _____

Address: _____ **City:** _____**Zip**_____

Home Phone: _____**Cell:** _____

Email: _____

Date of Birth: _____ **Age:** _____ **Birthplace:** _____

Occupation: _____ **How Long:** _____

Emergency Contact: _____ **Phone:** _____

Primary Care Doctor: _____ **Phone:** _____

Who referred you: _____

Medical Conditions: _____

Current Medications: _____

History of drug/alcohol use: _____

_____

Previous Counseling Dates/With whom? _____

_____

Briefly describe the reason you are here: _____

_____

What do you hope to achieve or accomplish? _____

_____

Please check behaviors and symptoms that occur to you more often than you would like:

___ Aggression	**___ Elevated mood**	**___ Phobias/fears**
___ Alcohol dependence	**___ Fatigue**	**___Recurring thoughts**
___ Anger	**___ Gambling**	**___ Sexual addiction**
___ Antisocial behavior	**___ Hallucinations**	**___ Sexual difficulties**
___ Anxiety	**___ Heart palpitations**	**___ Sick often**
___ Avoiding people	**___ High blood pressure**	**___ Sleep problems**
___ Chest pain	**___ Hopelessness**	**___ Speech problems**
___ Internet addiction	**___ Impulsivity**	**___ Suicidal thoughts**
___ Depression	**___ Irritability**	**___ Disorganized thoughts**
___ Disorientation	**___ Poor judgment**	**___ Trembling**
___ Distractibility	**___ Loneliness**	**___ Withdrawing**
___ Dizziness	**___ Memory problems**	**___ Worrying**
___ Drug dependence	**___ Mood swings**	**___ Other_____**
___ Eating disorder	**___ Panic attacks**	**_____**