Mindkind Counseling Services LLC Danica Rozario LPC, NCC
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INTAKE FORM PERSONAL DATA

Name: _____ Date: _____
Address: _____
Email: _____
Can I leave messages at this home and/or email address? Yes ___ No ___
Cell#: _____
Can I leave messages at this number? Yes ___ No ___
Employer/Occupation _____ Who referred you? _____

AREAS OF CONCERN

What concerns motivated you to seek therapy?

_____
_____
_____

When did these problems begin? _____
Are they getting better, worse or remaining the same? _____
What are your therapy goals?

_____
_____
_____

PERSONAL & FAMILY HISTORY:

Where were you born and/or grow up?

_____
_____

Did you experience any developmental, academic or behavior problems as a child? Yes ___ No ___
If yes, please explain:

_____

What is your highest level of education? _____
Did your parent's divorce? Yes___ No___ If yes, how old were you when they divorced?_____
Number of siblings: ___ Biological Brothers ___ Adopted Brothers ___ Stepbrothers ___ Biological Sisters ___ Adopted Sisters ___ Stepsisters
Were you the oldest, youngest, middle, or only child in your family?_____
When you were a child, did you ever suffer from physical, sexual, verbal or mental abuse? Yes ___ No ___
If yes, please briefly explain—who, what kind, how old were you on the back of this page.
Would you describe your childhood as (circle):
good bad traumatic happy sad stable lonely scary safe
Are you currently married/in a long-term relationship? Yes ___ No ___ If yes, for how long _____
Current spouse/partner: Name _____Age ____ Education _____ Occupation _____
If you have children, please list their names & ages: _____, _____, _____
Who lives in your household?

_____

DRUG & ALCOHOL HISTORY:

How much alcohol do you consume? ___ drinks per day/week (please circle)
Do you use any recreational drugs? Yes___ No____ If yes, what substances _____
Do you currently smoke cigarettes? Yes___ No___ How many per day? _____
Have you had treatment for alcohol or drugs? ____ If yes, please detail on back of page.

MEDICAL & PSYCHOLOGICAL HISTORY:

Please list any chronic medical illnesses (asthma, high blood pressure, diabetes, seizures, etc.):

_____

Have you ever been hospitalized for medical/psychiatric reasons? ____ If yes, please detail on back of page.
Name of current Psychiatrist (if you have one):

Have you been in counseling / therapy in the past?_____ If yes, when & for what?

Please list all current medications you are taking (give names & dosages):
Name: _____ (____mg)
Name: _____ (___mg)
Name: _____ (____mg)
Name: _____ (___mg)
Please describe any major health, medical or mental health problems among the following family members:
Father _____ Mother _____
Sisters _____ Brothers _____
Children _____ Grandparents _____
Is your father alive? Yes___ No___
Is your mother alive? Yes___ No___

ACTIVITIES OF DAILY LIVING:

Please describe a typical day for you
Morning:_____
Do you eat Breakfast? Yes___ No___
Noon: _____
Lunch? Yes___ No___
Evening: _____
Dinner? Yes___ No___
What do you do for fun? (Hobbies & interests):

Do you exercise? Yes ___ No ___ If yes, what kind and how often

Are you less social than you used to be? Yes ___ No ___ If yes,
why?_____
____

SPIRITUAL / FAITH BACKGROUND:

How do you describe yourself? (circle): Spiritual Religious Uncertain
Other_____
Spiritual affiliation(s): Present_____

PLEASE LIST SOURCES OF SUPPORT & STRENGTH IN YOUR LIFE:

Please use the following space or back of page to share any other information you would like to share that is not covered on this form but may be relevant: _____

_____/____/_____
Client Signature Date of Signature