Patient Intake

TRUE SELF COUNSELING SERVICES

Demographic/Patient Information

Legal Name* Last	First	Middle Initial	**Preferred name:**

Legal Sex (please check one)* ❑ **Female** ❑ **Male** **While True Self Counseling Services recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns that are different from these, please let us know.*	**Preferred pronouns:**

Date of Birth: Month Day Year / /	**Age**	**Birthplace**

Best Number to Reach You? ( )	**Ok to Leave Voicemail and/or text?** **Yes** ❑ **No** ❑

Local Address	City	State	ZIP
Billing Address (if different from above)	City	State	ZIP

Email address:

Emergency Contact's Name:	Phone Number	Relationship to you

If under 18, please provide parent (s)/guardian contact information.

Parent/Guardian Name	Phone Number	Relationship to you
Parent/Guardian Name	Phone Number	Relationship to you

Employment/Education Status

- ❑ Employed full time
  Position: _____
- ❑ Employed part time
  Position: _____
- ❑ Student full time (Grade:_____)
- ❑ Student part time (Grade:_____)
- ❑ Retired
- ❑ Homemaker
- ❑ Other _____
- ❑ Unemployed

Marital Status

- ❑ Married
- ❑ Partnered
- ❑ Single
- ❑ Divorced
- ❑ Other_____

Referral Source

- ❑ Self
- ❑ Friend or Family Member
- ❑ Health Provider
- ❑ Emergency Room
- ❑ Ad/Internet
- ❑ Other _____

Briefly state why you are seeking treatment at this time:

What are your goals/expectations from this treatment?

Medical History

Primary Care Physician's Name:	**Phone Number:**
Please list any medications you are currently taking:	
Please list any relevant medical condition or history:	

Mental Health History

Have you had previous psychotherapy/counseling?	Yes ❑	No ❑
Have you had previous psychiatric treatment?	Yes ❑	No ❑
Have you ever had psychological/psychoeducational testing?	Yes ❑	No ❑
Have you ever been hospitalized for mental health reasons?	Yes ❑	No ❑
History of any suicidal thoughts or threats:	Yes ❑	No ❑
Suicidal gestures or attempts:	Yes ❑	No ❑
History of physical abuse or assault:	Yes ❑	No ❑
History of sexual abuse or assault:	Yes ❑	No ❑
Have you ever received treatment for alcohol and/or drug use?	Yes ❑	No ❑
History of arrest or incarceration:	Yes ❑	No ❑
Additional Information:		

Family History

Do you have any children? Yes ❑ No ❑ If yes, what are the children's ages? _____	
Parent's Age: _____ Living: ❑ Deceased: ❑	Parent's Age: _____ Living: ❑ Deceased: ❑
Do you have any siblings (brothers/sisters)? Yes ❑ No ❑	What are your siblings ages?