CORNERSTONE COUNSELING OF PALM BEACH

INTAKE FORM

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as our therapy. Please type an X in front of the multiple-choice questions. This questionnaire will take approximately twenty (20) minutes to complete.

Patient's Name:
Date of Birth: Age: Gender: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
Number of children: Ages:
Employment Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other
Patient Referred By:
Brief Description of reason for coming in:
Address line 1:
Address line 2:
City: State: Zip Code:
Home Phone #: Cell Phone #: Work Phone #:
Email:
May we leave a message on your: ☐ Home Phone ☐ Cell Phone ☐ Work phone ☐ Email
Emergency Contact name & number:
Name of parent or guardian (if minor):

Insurance				
Primary Insurance Company:				
Insurance I.D. Number:				
Insurance Group Number:				
Social Security Number (Tricare clients only):				
Insurance Effective Date:				
Client's relationship to insured:	☐ Self	☐ Spouse	☐ Child	☐ Other
Primary Insured's Name (if different):				
Primary Insured's Date of Birth (if different):				
Primary Insured's Address (if different):				
Technical Communication				
What type of appointment reminders would you prefer?	☐ Email	☐ Text	☐ Phone	
Please create a user ID and password for our website (www.therapyappointment.com):				
User ID:	Temporary Password (you can change):			
Credit Card				
Please complete the credit card information below so that we can keep it on file and hold your first appointment.				
Credit Card Type:	☐ AMEX	☐ Visa	☐ MasterCard	☐ Discover
Cardholder's Name (as it appears on card):				
Billing Address (if different from above):				
Card #:	Exp. Date:	3-digit CID#:		

Mental Health
Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? ☐ Yes ☐ No
Reason for change:
Have you had any mental health services in the past? ☐ Yes ☐ No
Reason for change:
Are you currently taking any psychiatric prescription medication? ☐ Yes ☐ No
If yes, please list:
Have you been prescribed psychiatric prescription medication in the past? ☐ Yes ☐ No
If yes, please list:
Have you experienced a weight change in the last two months? ☐ Yes ☐ No
Do you consume alcohol regularly? ☐ Yes ☐ No
In one month, how many times do you have four or more drinks in a 24-hour period?
How often do you engage in recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Have you felt depressed recently? ☐ Yes ☐ No
If yes, for how long?
Have you had any suicidal thoughts recently? ☐ Yes ☐ No
If yes, how often?
Have you ever had suicidal thoughts in your past? ☐ Yes ☐ No
If yes, how long ago?
How often did you have these thoughts? ☐ Frequently ☐ Sometimes ☐ Rarely
Are you currently in a romantic relationship? ☐ Yes ☐ No
If yes, how long have you been in this relationship?
On a scale from 1 – 10 (10 being great), how would you rate the quality of your relationships?
In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

☐ ☐

Place an "X" in front of the issues below that apply to you:

☐ Extreme depressed mood	☐ Mood swings	☐ Rapid speech	☐ Extreme anxiety
☐ Panic attacks	☐ Phobias	☐ Sleep disturbance	☐ Hallucinations
☐ Memory lapse	☐ Alcohol/substance abuse	☐ Body complaints	☐ Eating disorders
☐ Repetitive thoughts	☐ Anxiety	☐ Time loss	☐ Repetitive behaviors
☐ Homicidal thoughts	☐ Suicidal attempts	☐ Trouble planning	
☐ Difficulty w/relationships			

Family Mental Health History

Please place an "X" in front of your answer for your family member, then indicate the member affected:

			Relationship:
Depression	☐ Yes	☐ No	
Anxiety Disorders	☐ Yes	☐ No	
Bipolar Disorder	☐ Yes	☐ No	
Panic Attacks	☐ Yes	☐ No	
Alcohol/Substance Abuse	☐ Yes	☐ No	
Eating Disorders	☐ Yes	☐ No	
Learning Disability	☐ Yes	☐ No	
Trauma History	☐ Yes	☐ No	
Domestic Violence	☐ Yes	☐ No	
Obesity	☐ Yes	☐ No	
Obsessive Compulsive Behavior	☐ Yes	☐ No	
Schizophrenia	☐ Yes	☐ No	

Employment

Are you currently employed?	☐ Yes	☐ No
If yes, who is your employer?		
What is your position?		
Are you happy in your current position?	☐ Yes	☐ No
Are you fulfilled in your current position?	☐ Yes	☐ No
Does your work make you stressed?	☐ Yes	☐ No
If yes, what are your work-related stressors?		

Physical Health
How is your physical health at the present time?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good
Please list any persistent physical symptoms or health concerns (chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):
Are you on any medication for physical / medical issues: ☐ Yes ☐ No
If yes, please list:
Have you suffered from any reproductive loss: ☐ Yes ☐ No
I am sorry to hear of your loss. Please check all that apply:
☐ Miscarriage ☐ Still Birth ☐ Abortion ☐ Other
Do you feel this loss has impacted your mental health? Please describe:
Any information you would like me to know about this loss:
Are you having any problems with your sleep habits? ☐ Yes ☐ No
☐ Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing dreams ☐ Other:
How many times per week do you exercise? Days: Hours: Minutes:
Are there any changes or difficulties with your eating habits? ☐ Yes ☐ No
If yes, which apply: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Restricting
Have you experienced a weight change in the last two months? ☐ Yes ☐ No

Spirituality
What is your religious or spiritual affiliation and are you an active participant?
Is there anything you would like me to know about your faith walk?
Other Information
List your strengths:
List areas you feel you need to develop:
What do you like most about yourself?
What are some ways to cope with life obstacles and stress?
What are your goals for therapy / what would you like to accomplish?