Wholeistic You, PLLC Intake Form

Name: ___________________________________ Address: ____

City: _________________________ State: _________________ Zip code:_________________________________

Phone # ________________________ Cell phone: _____________________ Email: _________________________

Last four of SS# __________________ Date of Birth: ______________ Age: ______ ☐ Male ☐ Female

Employer: ___________________________________ Occupation: _____________________________________

Please check any if reasons listed below which resulted in you coming to therapy today?

☐ Depression ☐ Anxiety ☐ Alcohol ☐ Drugs ☐ Marital Issues ☐ Family Counseling

☐ Relationship Enhancement ☐ Improvement Sexual Relations ☐ Abuse Sexual/Physical ☐ Individual Counseling

☐ Pre- Marital Counseling ☐ Communications Difficulties ☐ Difficulty with Death ☐ Divorce Counseling

☐ Other:____

History:

☐ Anxiety ☐ Depression ☐ Anger ☐ Addiction (Drugs/Alcohol)

☐ Withdrawn ☐ Constricted ☐ Hostile ☐ Other Mental Illness

What are your current symptoms?

____

____

How long have you experienced your current symptoms?

____

____

What made you come to treatment now?

____

____

What do you expect from Treatment?

____

____

Medical Problems?

____

____

Any Medications ?

____

____

____

Primary Physician: ____

Substance Abuse: ☐ Yes ☐ No

Have you ever been in treatment facility for substance abuse: ☐ Yes ☐ No

If yes above please explain:

____

____

____

Mothers Name: ____________________________________ Age: ___________ ☐ Deceased ☐ Living

If deceased cause of Death? ____

Substance Abuse? ☐ Yes ☐ No if yes please explain:

____

____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Fathers Name: ____________________________________ Age: ___________ ☐ Deceased ☐ Living

If deceased cause of Death? ____

Substance Abuse? ☐ Yes ☐ No if yes please explain:

____

____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Relationship Status:

☐ Single ☐ Cohabitating (Living Together) ☐ Divorced ☐ Separated ☐ Widowed

☐ Significant Other ☐ Remarried (After Divorced) ☐ Remarried (After Death) ☐ Married (First)

Significant others name:

____

If deceased cause of Death? ____

Substance Abuse? ☐ Yes ☐ No if yes please explain:
____
____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Child Name: ____________________________________ Age: ___________ ☐ Deceased ☐ Living

If deceased cause of Death? ____

Substance Abuse? ☐ Yes ☐ No if yes please explain:
____
____

Quality of Relationship:

☐ Great ☐ Good ☐ Fair ☐ Poor

Legal issues? ☐ Yes ☐ No If yes please explain: ____

Employed? ☐ Yes ☐ No Place of Employment: ____

How long at present position?
____

Do you have any pain? ____

Memory issues/ Examples:

____

____

Do you believe in a higher power? ☐ Yes ☐ No

Participate in Organized Religion? ☐ Yes ☐ No

What provides you with strength and hope?

____

____

____

Family History:

☐ Anxiety ☐ Depression ☐ Anger ☐ Addiction (Drugs/Alcohol)

☐ Withdrawn ☐ Constricted ☐ Hostile ☐ Other Mental Illness

How has your lifestyle background affected you?

____

____

Education Highest grade?

____

____

Do you want to go back to school?

____

____

____

Who do you look to for support?

____

Any thoughts or Intentions of Suicide or Homicide?

____

____

____

Emergency Contact: ____________________________________ Relationship: ______________________

Address: ____

Phone Number: ____

Therapists Signature: ____ Date: __________________________

Clients Signature: ____ Date: __________________________