The Heart Centered Life, LLC

Counseling For Counselors

Intake Form

Name: _____ Date: _____

Address: _____

Email: _____

Phone number: _____

Date of Birth: _____ Age: _____

Emergency Contact Name: _____ Phone: _____

Referred by: _____

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This information helps me to know more about you as we begin our work together. Please feel free to be as detailed, or brief, as you are comfortable with. If there are questions you are not comfortable answering at this time, simply skip them. Thank you for completing this form.

Where/To Whom do you go for support in your life?

What is your biggest concern in your life right now?

Please rate the following areas of your life (1= NOT at all satisfied…5=COMPLETELY satisfied) by placing an "X" next to the correct number:

Work	1___	2___	3___	4___	5___
Friendships	1___	2___	3___	4___	5___
Romantic relationship	1___	2___	3___	4___	5___
Physical health	1___	2___	3___	4___	5___
Emotional state	1___	2___	3___	4___	5___
Self-esteem	1___	2___	3___	4___	5___
Home life	1___	2___	3___	4___	5___
Spirituality	1___	2___	3___	4___	5___

What are your goals for our work together?

Have you had any previous therapy? If so, what brought you to therapy? How did that therapy end?

Is religion or Spirituality (or lack thereof) a significant part of your life? If so, please describe.

What losses have you had in your life?

Please describe type and frequency of any exercise that you get:

Please describe your diet:

Please list medications you are currently taking:

Do you now or have you ever used/done any of the following to make yourself feel better (put an "X" by any that apply):

____Alcohol
____Caffeine
____Cigarettes
____Drugs
____Extreme sports
____Focusing on other's behavior
____Food- over eating
____Food- not eating
____Gambling
____Laxatives
____Internet
____Masturbation
____Over Exercising
____Pornography
____Purging (vomiting)
____Relationships
____Self-harming (cutting, burning, other)
____Sex
____Shopping
____Video games

What else would you like me to know about you?