Hershey Counseling Center
1371 Sand Hill Road
Hummelstown, PA 17036

INTAKE FORM

Date: _____

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information

The purpose of this questionnaire is to gain a greater understanding of your current concerns.

Name: _____

What issues or concerns prompted you to seek counseling? _____

_____

_____

Have you been in counseling before? If yes, what was helpful, and what wasn't? _____

_____

Single ____ Married ____ Divorced____ Widowed ____ Date of Birth: _____

Children? _____ How Many? _____ Ages _____

Employed? Yes/No Employer: _____

Therapist's Notes:

_____

_____

_____

_____

Emergency Contact: Name: _____

Relationship to Client: _____

Phone: Home: _____ Cell: _____ Work:_____

Medical History

How would you rate your current physical health? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Are you currently under a doctor's care? If yes, for what conditions? _____

_____

_____

_____

Are you currently taking any prescription medications? _____ Yes_____ No Please list:

_____For_____Dosage_____How long?_____

_____For_____Dosage_____How long?_____

_____For_____Dosage_____How long?_____

_____For_____Dosage_____How long?_____

_____For_____Dosage_____How long? _____

How would you rate your current sleep habits? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Are you currently experiencing overwhelming sadness, grief, or depression? _____ Yes _____ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? _____ Yes _____ No

If yes, when did you begin experiencing this? _____

Are you currently or have you recently experienced suicidal or homicidal thoughts? _____ Yes _____ No

Have you experienced any significant life changes or stressful events recently? _____ Yes _____ No

If yes, please describe: _____

_____

_____

Drug and Alcohol History

Please place a checkmark beside all substances used.

		Amount/Frequency	How Recent
Alcohol	_____	_____	_____
Sedatives	_____	_____	_____

Caffeine	_____	_____	_____
Pain Killers	_____	_____	_____
Marijuana	_____	_____	_____
Crack/Cocaine	_____	_____	_____
Heroin	_____	_____	_____

Have you ever had any previous substance abuse or addiction treatment? _____ Yes _____ No

Have you had trouble stopping or controlling use of a substance? _____ Yes _____ No

What do you hope to improve with counseling? _____

_____

_____

What are your personal strengths? _____

_____

_____

What do you enjoy doing?

Diagnoses and Treatment Plan (Therapist will complete this section)

Axis I: ____ _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Treatment Plan

Issue	Goals	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____