resonate
Resonate Wellness

Individual Counselling Intake Form

Please complete this Intake Form. It helps us to more fully understand the nature of your challenge(s).

Name: _____

Address: _____

_____

Primary Phone: _____ May we leave a message? ☐ Yes ☐ No

Secondary Phone: _____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

* Please note: E-mail is NOT a secure or confidential means of communication.

Age: _____ Date of Birth _____

Marital Status:

☐ Married ☐ Never Married ☐ Divorced ☐ Separated

☐ Domestic Partnership ☐ Widowed

Children (First Name, Age, & Gender) _____ _____

_____ _____

_____ _____

How did you hear about us? _____

If referred, by whom? _____

What are your goals for therapy? _____

_____

_____

_____

_____

* Please note that all information that you provide in this document is deemed confidential and is protected accordingly.

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

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5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	

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Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

ADDITIONAL INFORMATION:

1. What is your current employment situation?

_____

Do you enjoy your current work situation? Is there anything stressful about your current work situation?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

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