synchronicity COUNSELING

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## Confidential Client Intake Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Phone: _____ Secondary Phone:_____
Leave message? ☐Yes ☐No Leave message? ☐Yes ☐No

Work Phone: _____ Email:_____
Leave message? ☐Yes ☐No Contact by email? ☐Yes ☐No

Occupation: _____ Best time/day to contact you:_____

Birth date: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Education Level: ☐ 8th Grade or Below ☐ High School ☐ Some College ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Have you been in counseling/therapy before? ☐Yes ☐No If yes, when: _____ Did it help? ☐Yes ☐ Some ☐No

Reason for therapy?_____

Have you or a family member ever attempted suicide?_____

Please list all medications you take: _____

Physician's Name: _____ Phone number: _____

Psychiatrist's Name: _____ Phone number: _____

Do you have any physical disabilities or chronic illnesses? (please list):_____

_____

Please circle any of the following that are currently troubling you:

| | | | | |
|---|---|---|---|---|
| Alcohol/Drug use | Eating Problems | Physical Abuse | Communication with Partner | Motivation |
| Self-Esteem | Sexuality | Verbal Abuse | Sexual Harassment | School/Educational |
| Assertiveness | Suicidal Thoughts | Sexual Abuse | Stress | Dating |
| Addiction | Alcohol or Drug Issues | Marriage/Spouse/Partner | Spiritual/Religious | Career |
| Appearance/Weight | Depression/Sadness | Loneliness | Work Stress | Time Management |
| Expressing Feelings | Anxiety/Panic | Perfectionist | Money/Financial Issues | Hopelessness |
| Grief/Loss | Worry/Fear | Shyness | Childhood Issues | Divorce/Break up |
| Meeting People/Friends | Anger/Rage | Sleep | PTSD | Parenting |
| Guilt | Helplessness | GLBT issues | Boredom | Traumatic Event |
| Homesickness | Stalking | Trust | Relationship issues | Family |

1) Emergency Contact:_____ Relationship:_____ Phone:_____

2) Emergency Contact:_____ Relationship:_____ Phone:_____

How did you hear about Synchronicity Counseling? _____