SOLUTIONIST
COUNSELING SERVICES
WHERE PEOPLE DEVELOP HEALTHY SOLUTIONS FOR EVERYDAY LIVING

Intake Form

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

Name: _____ _____ _____
(Last) (First) (MI)

Name of parent / guardian (*if under 18 years):* _____

Marital Status:

- ☐ Never Married
- ☐ Domestic Partnership
- ☐ Married
- ☐ Separated
- ☐ Divorced Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____May we leave a message? Yes _____No _____

Cell Phone / Other: (_____)_____May we leave a message? Yes _____No_____

Email:
_____
Please note: *Email correspondence is not considered to be a confidential medium of communication.*

May we email you? Yes_____ No _____

Referred by (*If any)* _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc?)

- ☐ No
- ☐ Yes

If yes, previous therapist / practitioner _____

9250 West Glades Road, Suite 209, Boca Raton Florida 33434
Phone: 561-923-0913 Email: Info@solutionistcounseling.com
www.solutionistcounseling.com

Additional Information:

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

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

What brought you here today?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Do you own a gun?
- ☐ Yes
- ☐ No

License?
- ☐ Yes
- ☐ No

Are you currently taking any prescription medications?
- ☐ Yes

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☐ No

Please list medications (*if any)*

Have you ever been prescribed psychiatric medication?

☐ Yes
☐ No

General Health and Mental Health

Information

How would you rate your current physical health?

☐ Very Good
☐ Good
☐ Satisfactory
☐ Unsatisfactory
☐ Poor

How would you rate your current sleeping habits?

Please list any specific sleep problems you are currently experiencing:

How many times a week do you generally exercise? _____

What types of exercise do you participate in?

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

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?

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☐ Yes ☐ No

If yes, when did you begin experiencing this? _____

Are you currently experiencing chronic pain?

☐ Yes ☐ No

If yes, please describe. _____

Do you drink alcohol more than once a week?

☐ Yes
☐ No

How often do you drink?

☐ Daily
☐ Weekly
☐ Monthly
☐ Infrequently
☐ Never

Are you currently in a romantic relationship?

☐ Yes
☐ No

What significant changes or stressful events have you experienced lately?

Have you experienced any traumas that you think we should address?

☐ Yes
☐ No

If yes, please explain briefly. _____

_____

Family Mental Health History

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

Family Member

Alcohol/Substance abuse
Anxiety
Depression
Domestic Violence

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Eating Disorders	Yes	No
Obesity	Yes	No
Obsessive Compulsive Behavior	Yes	No
Schizophrenia	Yes	No
Suicide Attempts by self or other family member	Yes	No
	Yes	No

Yes	No
Yes	No
Yes	No

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