COMPASS
COUNSELING & CONSULTING

Confidential Intake Information – Counseling

Please fill out this form to help us know more about you, so your counseling sessions can focus on what's most important to you. This information is confidential as outlined in our Professional Disclosure Statement, the Counseling Office Policies and HIPAA Notice of Privacy Practices posted at www.CompassCounselingConsulting.com and upon request. We would be happy to discuss those with you.

Name _____ Date _____

Phone # Cell Other

OK to leave messages at these phone numbers? ☐ Yes ☐ No OK to Text? ☐ Yes ☐ No
*Please note: regular texting/email is not considered confidential communication, see Office Policies for details.

Date and Place of Birth: _____ Age: _____

Gender Identity: Sex Assigned at Birth:

Address: _____

Email: _____ OK to email? ☐ Yes ☐ No

Current Employment: _____ Highest grade of education: _____

Do you enjoy your work? ☐ Yes ☐ No Are finances a major stressor for you? ☐ Yes ☐ No

Person and phone number of whom to call in emergency and relationship to you (Spouse, Parent, Child, Friend, etc.):

_____

Referral source or how you heard about us (psychologytoday.com, goodtherapy.com, Facebook, Instagram, search engine, company/person):

_____

Past/Present Medical Issues (Brief summary of major medical problems, surgeries, accidents, falls, illness, etc.):

_____

Medication you are presently taking and for what. (Brief summary):

_____

Have you or your family been affected by alcohol or drug use? (Brief summary):

_____

_____

Any suicide attempts or violent behavior (describe: ages, reasons, circumstances, how, etc.)

_____

_____

Have you or any of your family had concerns with depression, anxiety, suicide attempts, or mental illness?
☐ No ☐ Yes If "Yes," please explain briefly.

_____

_____

Are you involved in any current or pending civil or criminal litigations, lawsuits or divorce or custody disputes?
☐ No ☐ Yes If "Yes," please explain briefly.

_____

Current marital status: ☐ Never Married ☐ Married ☐ Partnered ☐ Separated ☐ Widowed
☐ Divorced ☐ Domestic Partnership ☐ Other: _____

Past and present significant relationships:

_____

_____

What other family do you have?

_____

Among your friends and family, whom do you count on for support?

_____

_____

Have you ever been diagnosed with a mental health disorder? □ No □ Yes If "Yes," please explain:

_____

Have you experienced counseling before? □ Yes □ No • Was it helpful? □ Yes □ No □ Somewhat

With Whom? _____When? _____

Reasons for prior therapy: _____ # of sessions: _____

How would you rate your:

Peace vs worry level?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor
Calmness vs tension level?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor
Current physical health?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor
Your eating habits?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor
Your exercise habits?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor
Your sleeping habits?	□ Very Good	□ Good	□ Satisfactory	□ Unsatisfactory	□ Poor

List any specific sleeping concerns: _____

Please describe yourself spiritually:

_____

What gives you the most joy or pleasure in your life? _____

What are your main worries and fears? _____

What are your most important hopes or dreams? _____

Please describe what you want to work on in therapy; what do you want to be different in your life?

_____

_____

As specifically as possible, what are your expectations of counseling? _____

_____

Do you have any concerns about the counseling process? _____

How long has this been troubling you? _____ yrs. How bad is it? □ Mild □ Moderate □ Serious □Severe

What else is related to this problem?

__ Abuse: Physical, Sexual, Emotional, Spiritual
__ Adjustment Difficulties
__ Alcohol, Drug Use
__ Anger, Hostility, Arguing, Irritability
__ Anxiety, Worry
__ Appetite, Weight Control, Diet Issues
__ Childhood Issues (Your Childhood)
__ Children, Childcare, Parenting
__ Communication Concerns
__ Concentration, Motivation
__ Conflicts: Relational, Personality
__ Decision Making Difficulties
__ Depressed Mood, Sadness, Crying
__ Divorce, Separation
__ Emotions, Mood Swings
__ Family Difficulties
__ Fatigue, Tiredness, No Energy
__ Fears or Panic
__ Feeling Unworthy
__ Financial, Money, Spending Concerns
__ Forgiveness Issues
__ Gender Identity
__ Grief, Loss, Mourning
__ Guilt, Shame
__ Hopelessness
__ Isolation, Loneliness, Shyness
__ Marriage: Conflict, Coldness, Infidelity
__ Molested as a Child
__ Nervousness, Tension
__ Obsessions, Compulsions
__ Personal Growth
__ Physical Health, Pain
__ Pregnancy, Abortion, Miscarriage
__ Recurring Thoughts
__ Raped (as a child or adolescent)
__ Raped (as an adult)
__ Self-Esteem
__ Sexual Concerns/Sexuality
__ Sleep Problems
__ Spiritual/Faith Concerns
__ Suicidal Thoughts, Feelings
__ Unable to Have Fun
__ Unwanted Sexual Contact (as a minor)
__ Unwanted Sexual Contact (as an adult)
__ Work, Career Concerns, Goals, etc.
__ Other: _____