Confidential Minor 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: Email:

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 Address: ____ OK to email? Yes No.

Current Employment (if applicable): ________________________________ Highest grade of education: ________________

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

Parents' or guardians' names and phone numbers:

____

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

____

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

____

Medications 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 custody disputes?
No Yes If "Yes," please explain briefly.

____

Have you been experiencing difficulties at school? (Brief summary):

____

____

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
__ 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
__ Molested as a Young Child
__ Nervousness, Tension
__ Obsessions, Compulsions
__ Personal Growth
__ Physical Health, Pain
__ Pregnancy, Abortion, Miscarriage
__ Recurring Thoughts
__ Raped (as a young child or adolescent)
__ Self-Esteem
__ Sexual Concerns/Sexuality
__ Sleep Problems
__ Spiritual/Faith Concerns
__ Suicidal Thoughts, Feelings
__ Unable to Have Fun
__ Unwanted Sexual Contact
__ Work, Career Concerns, Goals, etc.
Other: __________________