Live.Balanced.Life.LLC

Columbia, Maryland

COUNSELING INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name:

Date:

Date of Birth:

Relationship Status:

Age:

SSN:

Gender: F M

Home/Mobile Phone

Is it ok to leave a message for you at this number? Y / N

Work Phone:

Is it ok to leave a message for you at this number? Y / N

Email:

Is it ok to email you? Y / N

Mailing Address:

Current Employer:

Position Title:

Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work)

Emergency Contact Name & Relationship:

Emergency Contact Phone:

How were you referred?

If online, which website?

Behavior - circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Feelings - circle any of the following feelings that apply to you:

Angry	Restless	Hopeful	Envious	Bored
Conflicted	Fearful	Tense	Happy	Anxious
Contented	Relaxed	Annoyed	Lonely	Helpless
Energetic	Unhappy	Regretful	Panicky	Sad
Guilty	Depressed	Excited	Jealous	Hopeless

Physical - circle any of the following symptoms that apply to you:

Headaches	Visual disturbances	Hear things	Unable to relax	Back pain
Ory Mouth	Stomach trouble	Numbness	Excessive sweating	Fainting spells
Twitches	Palpitations	Skin problems	Flushes	Tingling
Sexual disturbances	Chest pains	Fatigue	Dizziness	Hearing problems
Bowel disturbances	Tremors	Tension	Bumping or itchy skin	Tics
Muscle spasms		Blackouts	Watery eyes	
	Rapid heart beat			Do not like being touched