Empower You Therapy & Coaching, LLC

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Intake Form

Please print out and complete this form & bring it to your first session

Your Name:_____ Today's Date: _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Marital Status: Married / Separated / Divorced / Single / Engaged / Remarried / Widowed / Other _____

Employment Status: Student / Employed / Retired / Other _____

Name of Employer / School: _____ Position: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home Tel: (_____)_____ May I leave a message? Y / N

Cell Tel: (_____)_____ May I leave a message? Y / N May I text? Y / N

E-mail: _____ Contact by email? Y / N

Best time & way to reach you: _____

In case of emergency, please contact:

Name #1: _____ Phone: _____ Relationship: _____

Name #2: _____ Phone: _____ Relationship: _____

History:

Why are you seeking counseling?

_____

_____

_____

What goals do you have for therapy?

_____

_____

_____

Have you ever been hospitalized for a mental health disorder? Y / N

If yes, when? _____

Are you currently receiving medical or psychiatric treatment from a physician? Y / N

Physician or psychiatrist: _____

Please list any prescribed medications:_____

_____

Have you had therapy before? ___Yes ___No If yes, what did you find helpful? _____

Unhelpful? _____

Please check all that apply:

	Depressed Mood		Past physical / sexual abuse		Grief / loss
	Crying Spells		Alcohol / Substance abuse		Concerns with parenting
	Sleep Difficulties		Trouble with memory		Work-related concerns
	Irritability		Confusion		Problems with school
	Difficulty with Motivation		Unusual thoughts		Legal problems
	Mood swings		Gambling		Money management
	Weight loss or gains		Impulsivity		Health problems
	Anxiety or panic attacks		Obsessive thoughts / behaviors		Recent health issues
	Perfectionistic thinking		Phobias / Fears		Muscular tension / headaches
	Eating Disorders		Easily distracted		Menstrual difficulties
	Body image		Difficulty completing tasks		Infertility
	Problems with anger		Relationship problems		Suicidal thoughts (past)
	Unwanted habits		Sexual concerns		Suicidal thoughts (present)
	Self harm (cutting, burning)		Sexual addiction		Other (specify)

On a scale of 1-10, how would you rate the quality of your current relationship? _____

What are some of the challenges you are facing in your current relationship? _____

_____

_____

Any stressors in the past 12 months? _____

_____

If you are in **a relationship please rate it in the following areas**, on a scale of 1-10 (10 being most satisfied):

	Communication		Spirituality / Faith		Social Life (as individual)
	Conflict Management		Parenting		Finances
	Sex & Physical Intimacy		Household Duties		Outside Support
	Life / Work Balance		Social Life (as couples)		Roles

How did you hear about us?

___Psychology Today ___Good Therapy. ___Internet/Google Search ___Person: _____

Permission to thank? ___No ___Yes If yes, please initial: _____

Would you like to receive Empower You TC newsletter? ___No ___Yes If yes, please initial:_____