insight
COUNSELING CENTER

Full Name: _____ Preferred Name: _____

Phone #: _____ Email: _____

Is it safe to contact you at the number above? Yes No

Home Address: _____

Date of Birth: ____/____/____ Referred By: _____

Emergency Contact: _____ Phone: _____

QUESTIONS

	Yes	No		Yes	No
Have you been in therapy before?	☐	☐	Are you in a relationship?	☐	☐
Are you currently on medication?	☐	☐	Do you have children?	☐	☐
If so, list here:			Are you employed?	☐	☐
			Do you have sleep issues?	☐	☐
Do you experience suicidal thoughts?	☐	☐	Have you had issues with addiction?	☐	☐
Do you have a PCP or Psychiatrist?	☐	☐	If so, describe here:		
If so, list here:					
			Have you had an eating disorder?	☐	☐

What are you hoping to achieve through therapy? _____

Do you have any concerns you would like me to know about? _____