Girard Counseling Services, PLLC
182 Grand St
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Intake Form

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider:
_____
□ Insurance Provider:
_____
□ My Website
□ Psychology Today website
□ Friend/Family: _____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization
Please provide:
Name of provider or facility:
_____
Location: _____
Dates of treatment: _____
Reason for treatment:
_____

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6 _12months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born?
_____

Where did you grow up?
_____
□ city □ suburbs □ country

In the section below identify if there is a family history of any of the following. If yes, please put a check mark next to the category.

Condition Please circle List Family Member

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Sexual Abuse yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Other diagnosed mental health condition?

Marital Status:

□ Never Married □ Domestic Partner □ Married

For how long?_____

On a scale of 110

(best), how would you rate your relationship? _____

□ Separated □ Divorced □ Widowed

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

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

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off label use. Continue on the back if needed, or provide a separate list.

Medication/Supplement

Dosage Condition Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Any change in weight over the past year? □ No □ Yes:

_____

Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

Additional Information

What do you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time?

What do you do to relax?

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?