Inner Light Counseling LLC
Rachel Moore, MA, LPC
Innerlightcounselinggolden@gmail.com
720-626-9799

Confidential Intake Form

Name of client: _____Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Parents' names if client is under 18:

_____

Marital/Relational Status: _____ Partner/Spouse Name:

_____

Children (Names and ages):

_____

Others living in client's
home:_____

Occupation: _____ Highest Level of Education: _____

CONTACT INFORMATION

Address: _____ Phone number(s):_____

_____

Email address: _____ Do you prefer I contact you by phone or email?_____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Address: _____ Phone:

_____

Alternate phone:_____

Health Insurance Information:

Name of Insurance Company:_____

ID #:_____

Group #:_____

Relation to Insurance Carrier:___ SELF_____ ___Other

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PAST YEAR CHECKLIST

Only respond to those areas that apply to you. Please rate the level of distress these issues have caused you in the past year:

0 1 2 3 4

None Minor Moderate Considerable Extreme

____Sleeping Too Much/Too Little

____Eating Too Much/Too Little

____Mood Swings

____Angry Outbursts

____Depression

____Repetitive Behaviors

____Anxiety/Fear

____Lack of Energy

____Hear/See things others cannot

____Suicidal Thoughts/Actions

____Physical/Emotion/Sexual abuse

____Drug/Alcohol (self or other)

____Loneliness

____Past Trauma

____Death/Major Loss

Please list major life or traumatic events:

1-

2-

EXPECTATIONS FOR THERAPY

What brings you to seek therapy now and what do you hope to gain?_____

_____

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Do you have any concerns about therapy?

_____

Past experiences in counseling/therapy? Yes ____ No_____

Positive or Negative?

_____

MEDICAL AND MENTAL HEALTH TREATMENT INFORMATION

Please describe your physical and mental health including significant hospitalizations, illnesses, and/or medications.

_____

_____

_____

Are you currently receiving other mental health services or medical treatments? _ Y_____ No_____

Describe:_____

SAFETY ASSESSMENT

Have you ever given serious consideration to, or attempted to end your own life? _____

_____

Last occurrence:

_____

If yes, do you currently feel this way? Have a plan?

_____

_____

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Have you ever given serious consideration to, or attempted to harm another person? _____

Last occurrence:

_____

_____

If yes, do you currently feel this way? Have a plan?

_____

SUBSTANCE USE

Do you currently use tobacco, alcohol, or other drugs?

_____

Substance #1 :_____ How much and how often? Past Use

_____

Substance #2 :_____ How much and how often? Past Use

_____

(If applicable) When you used the most, how much did you use?_____

Past substance abuse treatment? Y or N _____

LEGAL HISTORY

Are you involved in the legal system or have you had significant legal issues in the past? _____

_____

FAMILY INFORMATION

What are your current family dynamics if related to therapy:

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_____

_____

RELATIONSHIPS WITH OTHERS

Please describe the important people in your life and the quality of these relationships: _____

_____

Have you now or ever experienced violence, abuse, or threatening behavior in a relationship?_____Yes No_____

Do you have any concerns related to gender identity or sexual identity? YES or No

STRENGTHS AND RESOURCES

What helps you to make it through difficult times? (Animals, friends, personal qualities, etc.)

_____

Who can you count on for support in times of need?

_____

_____

What gives you personal enjoyment?

_____

What communities are you a part of?

_____

Do you have religious practices or spiritual beliefs that are important to you? Yes No

Is your cultural identity important to you? Yes_____ No _____