Ole Towne Counseling & Assessment Services
Intake Form

***Please complete all questions on this form (Please Print)**

Today's date____/____/____

Name of person filling out this form: _____
Relationship to client: _____

CLIENT INFORMATION

Name: _____Date of Birth: ____/____/____

Address: _____

Email Address: _____

Home Phone: (____) _____Work: (____) _____Cell: (____)_____

Age: _____ Gender: □ Male □ Female

Race (optional) □ African American □ Asian □ Hispanic □ White □ Other _____
(specify)

Have you ever received counseling or psychological services? □ Yes □ No If yes, please indicate why treatment was sought, whom provided treatment and results: _____

_____.

Have you ever been prescribed medications for psychiatric or emotional problems? □ Yes □ No

If yes, by whom and what medications were prescribed, and treatment results:_____

_____

Please list your primary care physician: _____

Phone: _____

Please describe any current medical illnesses/ health-related concerns or allergies: _____

_____

Please list any current medications you are taking:_____

_____

Please list any family history of mental illness or chemical dependency: _____

_____

Educational History

Please check any of the following concerns you experienced in school:

□ difficulty with reading
□ difficulty with math
□ difficulty with spelling
□ difficulty paying attention in class
□ difficulty sitting still in class
□ loses things
□ difficulty remembering things
□ difficulty respecting others' rights
□ difficulty with writing
□ problems getting along with peers
□ difficulty getting organized

Were you ever retained? □ Yes □ No

Name of last school attended: _____

Highest grade completed: _____

Social and Behavioral Status

Please place a check next to any behavior you **currently** exhibit:

□ Difficulty with hearing
□ Difficulty with coordination
□ Difficulty with balance
□ Difficulty making friends

□ Difficulty keeping friends
□ Prefer to be alone
□ Do not get along well with adults
□ Fight verbally with others
□ Much too active
□ Easily distracted

□ Disorganized
□ Unusually talkative
□ Shy or timid
□ Tire easily, have little energy
□ Daydream too much
□ Impulsive
□ Get hurt frequently
□ Engaged in self-harm
□ Slow to learn
□ Argumentative
□ Stare into space for long periods
□ Does not understand other's
□ difficulty following directions
□ Fight physically with others
□ Does not show feelings
□ Frequent crying spells
□ Unusual or special fears or mannerisms (describe)
_____
□ Frequent outbursts
□ Trouble sleeping
□ Show wide mood swings
□ Fidgety
□ Withdrawn (describe) _____

_____

□ Forgetful
□ Blank spells
□ Worry excessively
□ Take unnecessary risks
□ Stealing
□ Have low self- esteem
□ Move slowly
□ Difficulty getting along with others
□ Complains of aches or pains
□ In trouble with the law
□ Constantly seek attention

□ Give up easily
□ Show anger easily
□ Difficulty accepting criticism
□ Talks about wanting to die
□ Has poor attention span
□ Has poor memory
□ Afraid of new situations
□ Suspicious of other people
□ Drink alcohol
□ Restless
□ Have periods of confusion
□ Feel sad or unhappy often
□ Feel hopeless
□ Nervous or anxious
□ Easily frustrated
□ Has trouble making plans
□ Use illegal drugs
□ Other problems (describe) _____
_____

Employment:

Name of current employer and position held: _____

What do you consider to be your strengths?
_____

_____

What activities do you enjoy?_____

_____

Please add any other information you feel it would be helpful to share about yourself: _____

_____

_____

Please indicate your goals for treatment:

1. _____

2. _____

3. _____

Thank you for taking the time to complete this form.

Whom may I thank for referring you? _____