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Natural Balance

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COUNSELING CLIENT INTAKE FORM

Date _____/_____/_____

Name:_____ Date of Birth_____/_____/_____

Female ____ Male ____ Other____ Single ____ Married ____ Separated ___ Divorced ____ Widowed ___

E-mail Address (Home)_____
E-mail Address (Work)_____

Address:_____ Home Phone_____
_____ Cell Phone_____
City_____Zip_____

What is your reason for seeking counseling? _____

How do you hope to be helped by this counseling? _____

Have you had previous counseling?_____ If yes, what year/s and for how long?_____

What was your presenting issue at that time?_____

Did you receive a diagnosis? _____ If so, please list: _____

Are you taking any medications? _____ If yes, please list: _____
_____

In the past six months have you thought of harming yourself?_____
In the past six months have you thought of harming someone else?_____
Are you living with someone who has threatened, controlled, or abused you?_____
If yes, do you have a safety plan? _____
Have you ever lived with someone who has threatened, controlled or abused you?_____
Are you currently or have you in the past abused any substances? (if so, please describe)_____
_____

Do you currently have high blood pressure?_____ Diabetes?_____ Any other chronic illness/s?_____
If so, please list_____
Do you feel your physical problems contributes to your current situation?_____

PLEASE READ AND SIGN THE FOLLOWING

I understand that the above information is accurate to the best of my knowledge. I agree to the release of information for insurance Purposes, if applicable. I also understand that I will be given a separate disclosure statement and consent for treatment form.

I clearly understand that therapy treatments are my personal financial responsibility and I agree to pay for these services at
the time of treatment unless other arrangements have been made in advance.

I also understand that I will be charged for any appointments cancelled with less than 24 hrs. notice, except in cases of illness
or unforseen circumstances.

PATIENT
SIGNATURE_____Date_____