Annette Rembold, MA, LMHC

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(at the moment only telehealth)
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Confidential Intake Form

Date_____

Personal Information

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ OK to call this number? Y / N OK to leave a message? Y / N

Cell Phone: _____ OK to call this number? Y / N OK to leave a message? Y / N

Email Address: _____ OK to contact you via email? Y / N

Employer and Occupation: _____

Work Phone: _____OK to call this number? Y / N OK to leave a message? Y / N

Relationship Status:

___ Single __ Married __ Partnered __ Separated __ Divorced __ Widowed

Who are the members of your household? Please provide name, age, gender, and relationship.

_____

_____

Do you have any children who do not live with you? Please provide name, age, gender.

_____

Insurance Information:

1. Do you have insurance and do you want to use it? Yes / No
2. Name of insurance:_____ (is this the primary insurance? Yes/No)
   Member: self, other: _____ (name, relationship)
   If other, date of birth: _____
   ID: _____ group # _____

Mental Health Information

Have you been in counseling or therapy before? Y / N

If yes, please describe briefly, including the reason, the name of the therapist, approximate dates, and whether the counseling was helpful.

_____

_____

Please list any medication or supplements you are taking for your mental health, including the prescriber's name.

_____

_____

What prompted you to seek counseling now?

Please check any of the following that are issues for you:

	Insomnia		Career Issues		Repetitive thoughts
	Depressed Mood		Relationship Issues		Repetitive behaviors
	Mood Swings		Work Stress		Cutting/self-mutilation
	Anxiety		Financial Issues		Suicidal thoughts or attempt
	Panic Attacks		Sexual Issues		Urges to harm others
	Phobias		Sexual or gender identity issues		Hallucinations
	Anger issues		Spiritual or religious issues		Unexplained memory lapse
	Eating Disorder		Self-esteem issues		Grief or Loss
	Drug or Alcohol Abuse		Body image issues		Physical health issues

What goals do you have for yourself in counseling? _____

_____

_____

Health Information

Please describe any ongoing physical symptoms or health concerns (e.g., headaches, chronic pain, hypertension, diabetes, etc):

Name of Physician: _____ Phone _____

Please list any prescribed medications you are currently taking:

_____

How often do you drink alcohol? _____

Do you use recreational drugs (e.g., pot, cocaine, ecstasy, etc.)? Y / N

If so, what do you use, how much, and how often? _____

_____

Emergency Contact

In case of emergency, please contact:

Name: _____ Relationship: _____

Address: _____

Cell Phone _____ Home Phone _____ Work Phone _____

Name: _____ Relationship: _____

Address:_____

Cell Phone _____ Home Phone _____ Work Phone_____

How did you find out about my services? _____

Is it OK to thank them for your referral? Y / N

Client Signature: _____

Date_____