Laurel O'Connor LMFT
Confidential Intake Form

Today's Date ____________

Name (Adult or Parent/Guardian of minor)	Date of Birth	Occupation	Preferred Pronoun
Your Spouse/Partner	Date of Birth	Occupation	Preferred Pronoun
Home Address	City	Zip Code	
Telephone Cell - Prefer text? Yes/No	Telephone Other	Email address - Prefer email? Yes/No	
Emergency Contact Name	Telephone	Relation to you	

Employer

Do you have health insurance? Yes/No Name of Company:

Children *(oldest to youngest)*

Name	Gender	Preferred Pronoun	Date of birth	Age	School Grade

Is anyone else living in your house? If yes, give names and explain: ____

Describe any current or previous counseling: ____

Reason you are seeking help: ____

Goals for counseling: ____

Who referred you? ____

MEDICAL HISTORY

Have you ever been diagnosed with a serious illness? (e.g. infections, diseases, chronic pain, high blood pressure, etc.)
Explain:____

____

Are you currently taking any medications or supplements? Please describe: ______________________________

____

Are you experiencing any medical/physical symptoms that may contribute to mental/emotional/stress-related conditions? Please describe: ____

____

Please describe your overall health: ____

____

Are you physically active: ____

Primary physician and contact info: ____

FAMILY OF ORIGIN AND BACKGROUND HISTORY

Please briefly describe your childhood: ____

____

____

Mother's name, age if living or when deceased, your age at time of mother's death, description of your relationship:

____

____

____

Father's name, age if living or when deceased, your age at time of father's death, description of your relationship:

____

____

____

Names/Ages of siblings:____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe: _____________________

____

____

Have you been a victim of a violent crime? Please describe:_______________________________________

____

____

Do you engage in self-harm behaviors like cutting or other self-injury? Please describe: ___________________

____

Have you ever attempted suicide?____________When? ____

____

Are you currently having suicidal thoughts? Please describe: ____

____

____

Do you smoke/vape nicotine? **Yes/No** How much? ___________________ For how long? _______________________

Do you drink alcohol? **Yes/No** On average, how much do you drink in a week? ________________________________

____

Do you use Cannabis/CBD products? **Yes/No** On average, how much in a week?______________________________

____

Do you currently use illegal drugs? **Yes/No** Please describe your drug of choice: _______________________________

____

Have you ever abused prescription drugs? Please describe:____

____

OTHER INFORMATION

Please describe your spiritual orientation: ____

____

Please describe your interests and hobbies:____

____

Are you now or have you been involved in a lawsuit? ______If yes, please describe: ___________________________

____

Please feel free to include any other information, not previously requested; that you believe is relevant to your treatment:____

____

____

CHECK ITEMS THAT APPLY TO THE WAY YOU FEEL OR BEHAVE:

- ☐ headaches
- ☐ nightmares
- ☐ depressed
- ☐ always worried
- ☐ can't make decisions
- ☐ racing thoughts
- ☐ unable to relax
- ☐ fear loss of self-control
- ☐ can't go to sleep
- ☐ don't need a lot of sleep
- ☐ can't stay asleep
- ☐ always tired
- ☐ stomach problems

- ☐ bowel problems
- ☐ feel tense
- ☐ irritable
- ☐ panicky feelings
- ☐ unable to have good time
- ☐ can't get interested
- ☐ unable to work/study
- ☐ trouble concentrating
- ☐ bulimia/anorexia
- ☐ weight change
- ☐ binge/purge
- ☐ restrict food intake
- ☐ feel worthless

- ☐ feel apart from family
- ☐ conflict within family
- ☐ sexual problems
- ☐ financial problems
- ☐ can't make/keep friends
- ☐ fear things I shouldn't
- ☐ thoughts of suicide
- ☐ unusual thoughts
- ☐ strange experiences
- ☐ ready to explode
- ☐ like high-risk situations
- ☐ dizziness