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Whole Heart Counseling Services  
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Intake Form

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone/Cell \_\_\_\_\_

Email \_\_\_\_\_

Gender \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Single, Partnered, Married, Separated, Divorced, Other \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_

Number of Children \_\_\_\_\_ Referred by \_\_\_\_\_

Is it acceptable to call you at home? Yes No

If "no," how may I contact you? \_\_\_\_\_

At what phone number may I leave a message? \_\_\_\_\_

Are you currently under medical care? Yes No

If "yes," please explain/describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of personal physician and phone number: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking prescribed medications? Yes No

If "yes," then please explain/describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any psychiatric/mental health medications you have taken. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you been under the care of a psychiatrist, psychologist, or counselor? Yes No

If yes, please give the name, date, and location of the therapy, and briefly explain the nature of the problem that required attention. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please circle any of the following struggles that pertain to you:

Anxiety, Depression, Fears/Phobias, Sexual Problems, Suicidal Thoughts, Separation/Divorce, Relationships, Finances, Drug/Alcohol Use, Career Choices, Anger, Self-Control, Unhappiness, Insomnia, Religious Matters, Work/Stress, Health Problems, Cutting/Self-Mutilation, Thought Patterns, Other:

\_\_\_\_\_  
\_\_\_\_\_

In case of an emergency, notify:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

OR

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Client Signature:

\_\_\_\_\_

Client Signature:

\_\_\_\_\_