uFringo Counseling LLC

ADULT COUNSELING INTAKE FORM

Client Information

Client Name_____

Date of Birth_____

Address_____

_____

Home Phone_____ Work Phone_____

Cell Phone_____e-mail _____

Emergency Contact Information

Name _____

Address_____

_____

Home Phone_____ Work Phone_____

Cell Phone_____e-mail _____

Please list the names, relationship to, and ages of those you live with:

_____

_____

_____

How did you hear about uFringo Counseling?

_____

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CLINICAL INFORMATION

(For individual counseling, client should complete this section confidentially. For family counseling,each family member should individually complete a copy of this section)

What are your reasons for coming to counseling at this time?

What are your strengths, what are you good at?

What do you like to do in your free time?

Are you currently taking any medication? If yes list medication, dose, and name of prescribing physician:

Have you ever been hospitalized for physical illness or surgery? Yes No If Yes, please describe:

Have you ever been hospitalized for mental illness? Yes No
If Yes, please describe:

Have you received psychological help of any kind in the past? Yes No

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Please circle any and all characteristics you recognize might be causing you trouble now or in the recent past:

Anxiety or Worries	Disruptive Behavior	Poor Concentration	Unhappiness	Social Isolation
Shyness	Suspiciousness	Headaches	School/Job Performance	Chronic Pain
Drug Use	Too Much Energy	Pornography	Making Decisions	Divorce, Separation
Anger	Troublesome Thoughts	Insomnia	Stress	Friendship Troubles
Nightmares	Recurrent Thoughts	Binge Eating	Health Problems	Guilt
Relationship Issues	Problems with Authority	Low Self Esteem	Adoption and/or Attachment	Lack of Assertiveness
Sadness	Relationship w/Parents	Weight Control	Hyperactivity	Post Traumatic Stress
Fatigue or Tiredness	Depression	Grief	Anger	Self-Injury, Cutting
Loneliness	Sexuality	Abuse	Appetite	Sexual Harassment
Parenting Concerns	Alcohol Use	Mood Swings	Body Image	Other:
Sibling Relationships	Housing Problems	Fears	Impulsivity	Other:
Addiction	Self-Control	Suicidal Thoughts	Anorexia/Bulimia	Other:

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Have you ever thought about suicide?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever gotten so mad at someone that you wanted to hurt them?	Yes	No
Have you ever attempted to harm others in the past?	Yes	No

Thank you for completing this form.