Paul Lee, LCSW

INTAKE FORM

Name ____________________________ Birth date ___/___/____ Today's date ___/___/____

Address ______________________________________ Home phone ____________________

City/State/Zip___________________________________ Work phone ____________________

Email ____ Cell phone _____________________

Which number can we leave a message on? _____________

Gender _____ Marital status ___________

Household:
____Live with partner and/or children
____Live with parents/other family
____Live alone
____Live with roommate/other
____Other

Spouse/Partner's Name ________________________________ Phone ____________________

Address ____

City/State/Zip___________________________________ Work phone ____________________

Children (names and ages) ____

Please list any current or chronic medical conditions ________________________________

____

List any medications you are taking ____

Current work/occupation ______________________________ Employed now? ___Yes ___No

Main occupation in the past 5 years? ____

Highest grade completed ____________ Certificate/degree ____________________________

Emergency contact person ___________________________ Phone ______________________

How did you hear about us? ____

(Please turn this page over)

Have you been in counseling or psychiatric treatment before? ___ Yes ___ No
When? ____________

Purpose? ____

What are your reasons for coming to our agency? _________________________________

____

____

What are your goals for seeking counseling? ______________________________________

____

Please circle any of the following that concern you:

nervousness	depression	fears	shyness
sexual problems	suicidal thoughts	divorce	finances
anger	self-control	health problems	sleep problems
stress	work/school	relaxation	headaches
drug use	legal matters	memory	ambition
energy	insomnia	making decisions	bowel troubles
concentration	education	career	friends
stomach problems	inferiority feelings	nightmares	children
unhappiness	drinking	physical abuse	eating problems
loneliness	my thoughts	temper	tiredness
sexual abuse	parenting	self-harm	gambling

other: ____

Do you have concerns about your use of alcohol or any other substances? ____ yes ____no
Has anyone else expressed concern about your use of any substances? ____ yes ____no
If yes, which one(s)? (please circle)
alcohol tobacco cocaine amphetamines marijuana heroin other opiates
other____

Ethnic background (optional)

____ Caucasian ____ Asian American ____African American ____Hispanic

____Native American ____Pacific Islander ____Other Thank you.