Lisa Harrell
COUNSELING SERVICES

a:821 Raymond Avenue, Suite 440, St. Paul, MN 55114
p:651-587-3542 f:651-642-1908 e:lisa@lisaharrell.com w:www.lisaharrell.com

Intake Form

Date __________ Last Name ____________________________ First Name ________________________

Address ____

City ____ State _____________ Zip _____________________

Email Address ____ May I contact you by Email? __________

Home Phone _____________________ Work _____________________ Cell ________________________

Can I contact you and/or leave you a message at these numbers? ___________________________________

Sex (M/F) _____________________ DOB ____________ SS# ___________________________________

Occupation ___________________________________ Employer ___________________________________

Education (last grade completed) ___________ Referred here by ___________________________________

Reasons for seeking help at this time: ____

____

How have these concerns evolved over time? ____

____

What are your goals for our counseling work? ____

____

____

Family Information

Marital Status: Single ____ Engaged ____ Married _____ Separated _____ Divorced _____ Widowed _____
Living together _____ Remarried _____ For how long? ______________________________________

Partner or spouses name: ____

Please list the names and ages of any children: ____

____

Are your parents living? Y/N Names and ages of siblings: ______________________________________

____

Do any of your relatives have a history of mental illness? Y / N If yes, please explain: ____________ __

____

Medical Information

Are you currently under medical care? Y / N If yes, then please explain/describe: _____________________

____

Name of personal physician, address, & phone number: ____

____

Are you currently taking prescribed medications? Y/N If yes, then please list and explain purpose of medication:

____

Are you currently taking or have you ever been prescribed any medications, herbs, or supplements for depression or any other mental health condition? Y/N If yes, When? Prescribing Clinician? What Medication? For What? Results?____

____

Do you have any chronic illnesses? Please explain: ____

____

Have you ever been hospitalized for a psychiatric or emotional health reason? Y/N

When? Where? For what reason? Outcome? ____

____

Have you ever been in a drug, alcohol, or other treatment program? Y/N
When? Where? For what reason? Outcome? ____

____

List any psychiatric/mental health medications you have taken and explain the purpose of the medication: _____

____

Do you currently drink alcohol? Y / N If yes, how much? How often? ___________________________________

____

Do you currently use recreational drugs? Y / N If yes, how much? How often? ____________________________

____

Do you feel you have a problem with alcohol or drugs? Y / N

Overall physical condition: Very Good ____ Good ____ Average ____ Poor ____

Have you experienced any recent weight gain or weight loss? Y / N If yes, please explain: __________________

____

List any surgeries, accidents or serious illnesses and dates: ____

____

Have you been hospitalized in the last year for any reason? Y / N

When? Where? For what reason? Outcome? ____

____

Have you ever attempted or considered suicide? Y / N If yes, please provide any comments or thoughts:

______ ____

______ ____

Have you ever practiced cutting? Y / N If yes, please provide any comments or thoughts: ___________________

______ ____

______ ____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention and the outcome you experienced: ____

____

Was this experience: Very helpful ____Somewhat helpful ____Not helpful ____Made things worse ____

How significant of a role does spirituality play in your life?

None ____ Somewhat important ____ Significant ____ Very significant

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

Anxiety	Inability to Cry	Fears/Phobias	Eating Disorders
Panic Attacks	Crying Spells	Guilt	Difficulty Concentrating
Sexual Problems	Depression	Anger	Irritability/Impatience
Headaches	Suicidal Thoughts	Separation/Divorce	Relationships
Financial Problems	Drug/Alcohol Use	Career Choices	Thought Patterns
Self-Control	Unhappiness	Religious Matters	Rage Episodes
Work/Stress	Health Problems	Cutting/Self-Mutilation	Hitting people or Things
Chronic Pain	Legal Problems	Poor Self Image	Insomnia/Troubled Sleep
Memory	Grief	Loneliness	Other: ___________________

Is there anything else you think I should know about prior to our beginning your treatment? _______________

____

____

I understand that I am responsible to pay the entire cost of my sessions. I will give a 24 hour notice of cancellation for my appointment(s) (except for emergencies e.g. illness, car trouble, inclement weather) or I will pay the full amount due for the session I missed.

____ ____________________

Client Signature Date

I am required by law to obtain your signature as an indication that you have been given and have received a copy of the Client Bill of Rights and a copy of the Notice of Privacy Practices prior to the provision of service.

I have received a copy of the Client Bill of Rights.

____ ______________

Client Signature Date

____

Client Name (printed)

I have received the Notice of Privacy Practices.

____ ______________

Client Signature Date

____

Client Name (printed)