Innovative Counseling Partners, LLC

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date:__/__/__Age: ___________Gender: ____________

Marital Status:

- Never Married ◻ Domestic Partnership ◻ Married ◻ Separated
- Divorced ◻ Widowed

Please list any children/age:

____

____

INDIVIDUAL INFORMATION:

Height ________________Weight___________________

List Health Concerns

Primary

☐ Mild ☐ Moderate ☐ Disabling ☐ Constant ☐ Intermittent

☐ Symptoms ↑ w/activity

☐ Symptoms ↓ w/activity

☐ Getting worse ☐ getting better ☐ no change

Treatment received

Secondary

☐ Mild ☐ Moderate ☐ Disabling ☐ Constant ☐ Intermittent
☐ Symptoms ↑ w/activity
☐ Symptoms ↓ w/activity
☐ Getting worse ☐ getting better ☐ no change

Treatment received

List all conditions currently monitored by a Health Care Provider.

List Daily Activities

Work ______

Work Hours and Schedule ______

Do you now or have you ever worked the night shift? ☐ Yes ☐ No
If so, please explain ______

If currently, what are your hours? ______

HEALTH HISTORY

List & include dates & treatments. Add pages if necessary.

Surgeries ______

______

Accidents (physical-psychological) ______

______

Major Illnesses ______

Women

Last Pap ______ First day of last menstrual period ______

Marital/Partner History (Years Married) ______ Number of Children ______

Ages of Children ______ Number of pregnancies ______

Complications ______

Use of Contraceptive ☐ Yes ☐ No

What type? ______

Abortions/Miscarriages? ______

Men

Last Testosterone level:___________________ **Reading:__________________________**

Last Colonoscopy:_______________________ **Colonoscopy reading:________________**

Last Physical:___________________________ **Name of Physician:_________________**

DENTAL TREATMENT:

Dentist name:____

Last cleaning and checkup:___________________

21. MEDICATIONS (CURRENT & PAST USE)

In the table below, list any medications, including pharmaceuticals and antibiotics you are currently taking or have previously taken.

Medication	Prescribed for	Dosage	Frequency	Dates/Duration
Eg. Wellbutrin	Depression	100mg	2/day	2010-present

22. USE OF NON-PHARMACEUTICAL SUBSTANCES

Current	Past	Times per week / Comments
☐	☐	tobacco ______________________
☐	☐	alcohol/drugs ______________________
☐	☐	coffee/soda ______________________
☐	☐	other ______________________

Are you a recovering alcoholic? ☐ Yes ☐ No

History of drug or alcohol abuse? ☐ Yes ☐ No

Long term use of prescription/recreational drugs? ☐ Yes ☐ No

If yes, how often and in what form? ______________________

Do you use Nutrasweet (aspartame)? ☐ Yes ☐ No

23. USE OF NUTRITIONAL SUPPLEMENTS/HERBS/MINERALS

In the table below, please list any supplements, including vitamins, minerals, herbs, amino acids, and hormones that you are currently or have previously taken.

Supplements	**Manufacturer**	**Dosage**	**Frequency**	**Dates/Duration**
E.g. Vitamin C	Bronson	500mg	2/day	2012-4 months

26. CHECK ALL CURRENT AND PREVIOUS CONDITIONS

General

CURRENT	PAST	Comments
☐	☐ headaches	
☐	☐ pain	
☐	☐ sleep disturbances	
☐	☐ fatigue	
☐	☐ infections in the ears	
☐	☐ fever	
☐	☐ sinus	
☐	☐ other	

Skin Conditions

C	P	Comments
☐	☐ rashes	
☐	☐ athelete's foot, warts	
☐	☐ other	

Allergies

C	P	Comments
☐	☐ scents, oils, lotions	
☐	☐ detergents	
☐	☐ other	

Muscles and Joints

C	P	Comments
☐	☐ rheumatoid arthritis	
☐	☐ osteoarthritis	
☐	☐ scoliosis	
☐	☐ broken bones	
☐	☐ spinal problems	
☐	☐ disk problems	
☐	☐ lupus	
☐	☐ TMJ, jaw pain	
☐	☐ spasms, cramps	
☐	☐ sprains, strains	
☐	☐ tendonitis, bursitis	
☐	☐ stiff or painful joints	
☐	☐ weak or sore muscles	
☐	☐ neck, shoulder, arm pain	
☐	☐ low back, hip, leg pain	

Nervous System

C	P	Comments
☐	☐ head injuries, concussions	
☐	☐ dizziness, ringing in the ears	
☐	☐ loss of memory, confusion	
☐	☐ numbness, tingling	
☐	☐ sciatica, shooting pain	
☐	☐ chronic pain	
☐	☐ depression	
☐	☐ other	

Respiratory, Cardiovascular

C	P	Comments
☐	☐ heart disease	
☐	☐ blood clots	
☐	☐ stroke	
☐	☐ lymphadema	
☐	☐ high, low blood pressure	
☐	☐ irregular heart beat	
☐	☐ poor circulation	
☐	☐ swollen ankles	
☐	☐ varicose veins	
☐	☐ pregnancy	
☐	☐ chest pain, shortness of breath	
☐	☐ asthma	
☐	☐ palpable heartbeat in abdomen	
☐	☐ other	

Digestive/Elimination System

C	P	Comments
☐	☐ bowel dysfunction	
☐	☐ gas, bloatingbladder/kidney dysfunction abdominal pain	
☐	☐ ulcers, colitis	
☐	☐ belching/gas within 1 hour after eating	
☐	☐ heartburn/acid reflux	
☐	☐ bloating within 1 hour after eating	
☐	☐ bad breath (halitosis)	
☐	☐ sweat has strong odor	

Digestive/Elimination System (Cont.)

C	P	Comments
☐	☐	feel like skipping breakfast
☐	☐	feel better if you don't eat
☐	☐	sleepy after meals
☐	☐	stomach pains/cramps
☐	☐	diarrhea
☐	☐	undigested food in stool
☐	☐	pain between shoulder blades
☐	☐	stomach upset by greasy foods
☐	☐	nausea
☐	☐	light or clay colored stools gallbladder attacks
☐	☐	diarrhea
☐	☐	undigested food in stool
☐	☐	pain between shoulder blades
☐	☐	stomach upset by greasy foods
☐	☐	nausea
☐	☐	light or clay colored stools
☐	☐	gallbladder attacks
☐	☐	gallbladder removed
☐	☐	hemorrhoids or varicose veins
☐	☐	chronic fatigue / fibromyalgia
☐	☐	pulse speeds after eating
☐	☐	airborne allergies, hives
☐	☐	sinus congestion, "stuffy head"
☐	☐	crave bread or noodles
☐	☐	alternating cons-tipation/diarrhea crohn's disease
☐	☐	asthma
☐	☐	sinus infections
☐	☐	use over-the-counter pain medications
☐	☐	anus itches
☐	☐	history of antibiotic use
☐	☐	fungus or yeast infections
☐	☐	irritable bowel/colitis
☐	☐	other

Endocrine System

C	P	Comments
☐	☐	thyroid dysfunction
☐	☐	HIV/AIDS
☐	☐	diabetes
☐	☐	other

Reproductive System

C	P	Comments
☐	☐	pregnancy
☐	☐	reproductive problems
☐	☐	painful, emotional menses
☐	☐	fibrotic cysts
☐	☐	Cancer/Tumors
☐	☐	benign malignant

Electronic Usage

Understand client's daily electronic habits, including: cell phone, computer, tablet, online gamging (all platforms), and social media

Circle One

About how many minutes/hours do you spend texting daily?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
Talking on cell phone?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
Answering/sending emails?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
	Total Daily Time:

Circle One

About how many minutes/hours do you spend daily engaging in social media (facebook, Instagram, twitter, snapchat etc..)?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
Play games via cell phone (candy crush, words with friends, etc...)?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
Playing games via computer (minecraft, wizard 101, etc..)?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
Playing games via TV (play station, PS4, etc...)?	5-30 minutes // 30 minutes-1hour // 1 hour – 2 hours // 2 hours +
	Total Daily Time: