Wisconsin Wellness Counseling

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Client Intake Information

Please fill in this form as completely as possible and bring it to your first appointment.
All information on this form is protected under HIPAA regulations.

Personal Information **Date**: _____

Name: _____ DOB: _____ Age: _____

Parent/Guardian if client is under age 18): _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone:_____

Email: _____

(*Email cannot be protected and all electronic communication is susceptible to hacking/intrusion*.)

Please indicate by circling Yes or No where a message can be left:

Home Phone: Yes No; Cell Phone: Yes No; Work Phone: Yes No; Other Phone: Yes No: Email: Yes No

Relationship Status:

Married: _____ Married but Separated: _____ Domestic Partnership: _____ Never Married: _____

Divorced: _____ Widowed: _____ Have Significant Other:_____ Currently not in a Relationship:_____

Live with Significant Other: _____ Do not live with Significant Other: _____

Current Employment/Occupation: _____

Partner/Spouse's Employment Occupation: _____

Please circle any of the following that are important resources for you:

Spirituality Religion Faith

If you circled any of the three, what spiritual/religious/faith systems or traditions are important in your life? _____

_____

_____

History

Have been in therapy previously: Yes / No

Previous therapist(s):_____

_____

Psychiatric medication you have taken in the past: _____

_____

_____

Medication and/or supplements you are currently taking: _____

_____

_____

Current physical health problems/conditions (if any, including chronic pain): _____

_____

_____

_____

Any sleep problems you are experiencing: _____

_____

Exercise habits: _____

_____

_____

_____

Food habits (such as appetite problems, over-/undereating, stress eating, healthy eating, etc.):_____

_____

_____

_____

Emotional Health Concerns

Please mark the box ☒ if you are currently experiencing any of the following:

☐ **Anxiety**	☐ **Sadness**	☐ **Depression**
☐ **Grief**	☐ **Phobias**	☐ **Worry**
☐ **Feeling trapped**	☐ **Relationship problems**	☐ **Addictions or Addictive Behaviors**

Please rate how often (and in what quantity) you use the following:

Caffeinated beverages: _____

Alcoholic beverages: _____

Recreational drugs (and the type): _____

_____

Stressful life events you have experienced in the last ten years:

_____

_____

_____

_____

_____

Family History

If you are aware of any of the following conditions among your family, please mark the box ☒.

☐ **Depression**	☐ **Anxiety**	☐ **Alcohol/Substance Abuse**
☐ **Eating Disorders**	☐ **Obesity**	☐ **Domestic Violence**
☐ **Divorce**	☐ **Suicide Threats or Attempts**	☐ **Other** (please specify)

_____

Reasons you are seeking therapy at this time:

_____

_____

_____

_____

_____