Tree of Life Wellness Services, LLC

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Intake Form-Counseling Today's date ______________________
Name (s):____
Address:____
Date of birth: ___________ Day phone____________________ Eve phone_______________
Cell/other___________________Email address _______________________________________
How would you prefer I contact you? ____________________ OK to leave msg? _________

Emergency contact name __________________________ Relationship___________________
Daytime phone: ________________________ Evening phone:__________________________
Is it okay if I leave a message with that person, identifying myself as your therapist, in case of an emergency? yes no
Marital status: single living together married divorced/separated widowed
Are you currently taking medication? _____ If yes, please list: __________________________
____
Occupation _______________________How did you hear about me? ____________________
If applicable: Health Insurance Type ________________ID number ______________________
Social Security Number if you are an EAP client: ______________________________________

What are your main concerns?
____
____
____
____

Please mark any that apply to you:

___Anxiety, fear, or nervousness
___Concerns about my eating habits
___Concerns about an eating disorder
___Depression/sadness/crying
___Drug or alcohol use – self / other persons'
___Difficulty adjusting to a new situation
___Difficulty trusting people
___Domestic violence
___Feel tired, dizzy, or weak
___Family, parenting, or relationship concerns
___Financial concerns
___Gambling problems
___Headaches, indigestion, or muscle pains
___Legal problems
___Loss/grief
___Memory problems
___Mood swings
___Other person's mental health problems
___Overwhelmed by stress
___Racing thoughts
___Self-esteem/assertiveness concerns
___Sexual concerns
___Sexual orientation concerns
___Sleeping too much/little
___Sometimes I don't know where I am
___Sometimes I see/hear things others don't
___Thoughts of hurting self or others
___Trauma
___Victim of unwanted sexual experience
___Victim of violence
___Weight gain or loss
___Work or career problems