

# 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: \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

What are your main concerns?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mark any that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety, fear, or nervousness               | <input type="checkbox"/> Mood swings                              |
| <input type="checkbox"/> Concerns about my eating habits             | <input type="checkbox"/> Other person's mental health problems    |
| <input type="checkbox"/> Concerns about an eating disorder           | <input type="checkbox"/> Overwhelmed by stress                    |
| <input type="checkbox"/> Depression/sadness/crying                   | <input type="checkbox"/> Racing thoughts                          |
| <input type="checkbox"/> Drug or alcohol use – self / other persons' | <input type="checkbox"/> Self-esteem/assertiveness concerns       |
| <input type="checkbox"/> Difficulty adjusting to a new situation     | <input type="checkbox"/> Sexual concerns                          |
| <input type="checkbox"/> Difficulty trusting people                  | <input type="checkbox"/> Sexual orientation concerns              |
| <input type="checkbox"/> Domestic violence                           | <input type="checkbox"/> Sleeping too much/little                 |
| <input type="checkbox"/> Feel tired, dizzy, or weak                  | <input type="checkbox"/> Sometimes I don't know where I am        |
| <input type="checkbox"/> Family, parenting, or relationship concerns | <input type="checkbox"/> Sometimes I see/hear things others don't |
| <input type="checkbox"/> Financial concerns                          | <input type="checkbox"/> Thoughts of hurting self or others       |
| <input type="checkbox"/> Gambling problems                           | <input type="checkbox"/> Trauma                                   |
| <input type="checkbox"/> Headaches, indigestion, or muscle pains     | <input type="checkbox"/> Victim of unwanted sexual experience     |
| <input type="checkbox"/> Legal problems                              | <input type="checkbox"/> Victim of violence                       |
| <input type="checkbox"/> Loss/grief                                  | <input type="checkbox"/> Weight gain or loss                      |
| <input type="checkbox"/> Memory problems                             | <input type="checkbox"/> Work or career problems                  |