Sara Guy Counseling LLC

QUALITY CARE YOU CAN COUNT ON

**SARA GUY COUNSELING LLC**
**MINOR PSYCHOTHERAPY INTAKE FORM**

Client Name: ________________________________________ Today's Date: _____________

DOB: ______________________ Age: ______________ Gender: M F T

Parent / Caregivers Name: ________________________________________________________________

Parent / Caregivers Name: ________________________________________________________________

Home Address: ________________________________________________________________________

City: ___________________________ State: _______________________ Zip Code: _______________

Phone: _______________________________ Ok to leave a Message? Y N Ok to Text: Y N

Work Phone: ___________________________ Ok to leave a Message? Y N

Best day and time to call: __________________ Email: ______________________________________

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Insurance Provider Name: ____________________________ Policy Number: _____________________

Insurance Phone Number: __________________________________

Cash Pay Client _______ Yes ______ No

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1. How did you hear of this counseling provider?

   ________________________________________________________________________________

   ________________________________________________________________________________

2. Have you ever been connected to mental health services?

   ________________________________________________________________________________

   ________________________________________________________________________________

3. Have you ever been inpatient before? And for what reasons?

_______________________________________________

_______________________________________________

4. Do you currently use alcohol?

_______________________________________________

_______________________________________________

5. Do you currently use substances and if so which ones?

_______________________________________________

_______________________________________________

6. Are you currently experiencing any suicidal ideations? _____ Yes _____ No

7. Are you currently experiencing any homicidal ideations? _____ Yes _____ No

8. Are you currently experiencing any audio or visual hallucinations that no one else can see at this time? _____ Yes _____ No

9. How would you describe yourself?

_______________________________________________

_______________________________________________

10. Who lives at home with you?

_______________________________________________

_______________________________________________

11. Do you take any medications? If so, what are the medications and dosages?

_______________________________________________

_______________________________________________

12. Who is your Primary Care Provider? (please list their name and phone number):

_______________________________________________

_______________________________________________

13. What do you hope to gain from this experience?

_______________________________________________

_______________________________________________

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14. What should I know about you that I don't already know?

______________________________________________________________________________

______________________________________________________________________________

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