

Sara Guy Counseling LLC



QUALITY CARE YOU CAN COUNT ON

SARA GUY COUNSELING LLC ADULT PSYCHOTHERAPY INTAKE FORM

Client Name: _____ Today's Date: _____

DOB: _____ Age: _____ Gender: M F T

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: _____

Insurance Provider Name: _____ Policy Number: _____

Insurance Phone Number: _____

Cash Pay Client _____ Yes _____ No

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?

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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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