INNER PEACE
COUNSELING CENTER
Support for Individuals, Couples, & Families
Charlotte Location (Colonnade Executive Suites) 1811 Sardis Rd. North, Charlotte, NC 28270
Huntersville Location (Daetwyler Plaza) 13420 Reese Blvd., West, Huntersville, NC 28078

CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and BEFORE your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Address: _____

City:_____ **Zip Code:** _____

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership
□ Married □ Separated
□ Divorced □ Widowed

Please list any child(ren) & age(s): _____

E-mail: _____ May we email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
No
Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

No
Yes
Please list: _____

_____

Have you ever been prescribed psychiatric medication?
No
Yes
Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
No
Yes
If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
No
Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
No
Yes
If yes, please describe: _____

8. Do you drink alcohol more than once a week?
□ No
□ Yes

9. How often do you engage recreational drug use?
□ Daily
□ Weekly
□ Monthly
□ Infrequently
□ Never

10. Are you currently in a romantic relationship?
□ No
□ Yes
If yes, for how long? _____

11. On a scale of 1-10, how would you rate your relationship? _____

12. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior (OCD)	yes/no	
Schizophrenia or Paranoia	yes/no	
Suicide Attempts	yes/no	
OTHER: (list)		

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious?
□ No □ Yes
If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some things you may need to work on?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____