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Clinical Mental Health Counselor

Counseling Intake Form

Please note that all fields preceded by an asterisk must be filled in.

When completed, fax this form back to us at **520-203-0179**.

*Client Name: First _____ Middle initial ___ *Last _____

*Street _____ *City _____ *State ___ *Zip _____

Work Phone _____ Home phone _____ *Your Age Today _____

*Cell Phone _____ Fax Number _____ *Date of Birth _____

*Email Address _____ Social Security # _____

*Check one: Office Visits Skype

*Payment Method: Private or Group Insurance Medicaid Private Pay

Insurance Company _____ Client ID # _____

Insured Name _____ Insured ID # _____

*Describe your ethnicity. _____

*Describe your occupation and your daily routine. _____

*If married, Name of Spouse _____ Age of Spouse _____

If applicable: Number of Marriages for You _____

If applicable: Number of Marriages for Spouse _____

Names, ages and relationship to you of those living in your house. _____

Names and ages of your other children not living with you. _____

If you are seeking help for yourself, describe the problem with as much relevant detail as you can. If you are seeking help for your family or any member of it, beside yourself, state their name as well as describing the problem. Use additional sheets if necessary.

If you are experiencing any of the items below, please check them.

- | | |
|---------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Sadness/tearfulness | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Overly energetic |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Feel little or no need to sleep |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Rapid speech |
| <input type="checkbox"/> Sleeping to much | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Over-active in sex or spending |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Grandiosity |
| <input type="checkbox"/> Eating to much | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Irritability: | <input type="checkbox"/> Loss of the love of a loved one |
| <input type="checkbox"/> Loss of pleasure in life | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Seeing things that aren't there |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Binge eating |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Purging food |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Afraid to leave home | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Emotional abuse victim |
| <input type="checkbox"/> Inattentiveness | <input type="checkbox"/> Physical abuse victim |
| <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Sexual abuse victim |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Emotional abuse perpetrator |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Physical abuse perpetrator |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Sexual abuse perpetrator |

If you are experiencing suicidal or homicidal thoughts, if you are self-cutting or other type of self-harming, please explain in detail. If you are not experiencing any of these write "none." Use additional sheets if necessary. _____

If you are experiencing any bizarre or unusual behaviors (hearing voices, etc.) please explain in detail. If none, enter "none". _____

Give a complete history of your use of alcohol and drugs including cigarettes and any abuse of medication. Tell when you started, when it became a problem and your current use in the past year, month and week. If you have no alcohol or drug history, enter "none." _____

Tell more, if you think it would help explain your situation, about any of the above checked conditions not already covered. _____

Tell about any psychiatric hospitalizations (when, where and why). If none, enter "none".

Tell about any current or previous mental health counseling (when, where and why). If none, enter "none". _____

Tell any medical problems you have or have had (chronic illnesses, traumatic injuries, head injuries, major surgeries, chronic pain, etc.). If none, enter "none". _____

Tell anything else you think would be helpful for me to know about you. _____
