Creative Solutions Counseling
9800 Hillwood Parkway, Suite 140
Fort Worth, TX 76177

Intake Form

(Form to be completed by individual and/or parent receiving services)

GENERAL INFORMATION:

Date: _____ Referred by:_____

Full Name:_____

Name you prefer: _____ Date of Birth:_____ Age:_____

Race: □ White □ Black □ Latino □ Asian □ Other: Gender: □ Male □ Female

CONTACT INFORMATION:

Street Address:_____ Apt. #:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Mobile Phone: (_____)_____ Other Phone: (_____)_____

E-mail Address:_____

How do you prefer to be contacted? □ Home □ Work □ Mobile □ E-mail

EMERGENCY CONTACT:

Name:_____ Relationship:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Mobile Phone: (_____)_____ Other Phone: (_____)_____

E-mail Address:_____

CURRENT RELATIONSHIP INFORMATION (OF PARENT IF CHILD IS UNDER 18):

Marital Status:

□ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Co-habituating

If Married, How long?_____

# of Previous Marriages for You?_____ Your Spouse?_____

If Separated or Divorced, How long?_____ If Widowed, How long?_____

With Whom Do You Currently Live (Check all that apply): □ Alone □ Spouse

□ Children(#____) □ Parents □ Sibling(s) □ Boyfriend/Girlfriend □ Other:_____

FAMILY HISTORY:

Father's Name: _____

Age:_____ Race: □ White □ Black □ Latino □ Asian □ Other: _____

Father's Mental Health History:

_____

_____

Mother's Name:_____

Age:_____ Race: □ White □ Black □ Latino □ Asian □ Other:_____

Mother's Mental Health History:

_____

_____

MEDICAL HISTORY:

Primary Care Physician:_____

Phone #: _____

Rate your current level of health: □ Very Good □ Good □ Fair □ Poor □ Very Poor

List any medical problems:

_____

What prescription medications are you taking?

_____

What over-the-counter medications do you regularly take?

_____

Have you been in any type of accident (automobile or fall) in the past year? □ None

If so, please explain.

_____

On average, how many hour do you sleep each night?_____

Have you gained/lost more than 10 pounds in the past month? □ Yes □ No

How much?_____

Do you suffer from chronic pain? □ Yes □ No How long has this been a problem?

_____

LEGAL HISTORY:

Do you have any pending legal charges?_____

SUBSTANCE ABUSE HISTORY:

Do you drink coffee/caffeinated drinks? □ Yes □ No How much? How often?

_____

Do you smoke cigarettes? □ Yes □ No How much? How often?

_____

Do you drink alcohol? □ Yes □ No How much? How often? Which kind(s)?

_____

Do you use other drugs? □ Yes □ No How much? How often? Which one(s)?

_____

COUNSELING HISTORY:

Are you currently seeing a psychiatrist? □ Yes □ No

Psychiatrist Name:_____

Phone #:_____

Have you ever had individual counseling? □ Yes □ No For how long? _____

What were the results of the individual counseling?

_____

_____

Name and Location of Counselor:_____

Was counseling helpful? □ Yes □ No

Have you ever had family counseling? □ Yes □ No For how long?_____

What were the results of the family counseling?

_____

_____

Name and Location of Counselor:_____

Was counseling helpful? □ Yes □ No

Has anyone in your family ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, who and which type?_____

Have you ever tried to harm yourself? □ Yes □ No When?_____

What was your plan? _____

Have you ever tried to harm someone else? □ Yes □ No When?_____

What was your plan?_____

REASONS FOR SEEKING HELP:

Please describe why you are seeking counseling now: _____

_____

_____

Please check any of the following problems that apply to your child and/or your family:

Aggressiveness □ Child □ Family	**Legal Problems □ Child □ Family**
Alcohol Use □ Child □ Family	**Loneliness □ Child □ Family**
Anger □ Child □ Family	**Memory □ Child □ Family**
Anxiety □ Child □ Family	**Mood Swings □ Child □ Family**
Bad Dreams □ Child □ Family	**Nervousness □ Child □ Family**
Communication □ Child □ Family	**Obsessions □ Child □ Family**
Concentration □ Child □ Family	**Panic □ Child □ Family**
Depression □ Child □ Family	**Physical Abuse □ Child □ Family**

Disaster □ Child □ Family	**Pregnancy □ Child □ Family**
Divorce □ Child □ Family	**Recent Death □ Child □ Family**
Drug Use □ Child □ Family	**Recent Loss □ Child □ Family**
Eating Problem □ Child □ Family	**Risky Behavior □ Child □ Family**
Emotional Abuse □ Child □ Family	**Self-Control □ Child □ Family**
Fatigue □ Child □ Family	**Self-esteem □ Child □ Family**
Fears □ Child □ Family	**Sexual Abuse □ Child □ Family**
Gambling □ Child □ Family	**Shyness □ Child □ Family**
Grief □ Child □ Family	**Sleep Problems □ Child □ Family**
Guilt □ Child □ Family	**Stress □ Child □ Family**
Hopelessness □ Child □ Family	**Suicidal Thoughts □ Child □ Family**
Headaches □ Child □ Family	**Trauma □ Child □ Family**
Health Issues □ Child □ Family	**Verbal Abuse □ Child □ Family**

After Hours Policy/Procedures
If you need to contact your therapist at any time, you may do so by leaving a message on their voicemail. If needed, you should discuss other alternative means of contact with your therapist. If you are in crisis, please call 911. Creative Solutions Counseling is not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs.

NOTICE: Creative Solutions Counseling will not participate in any legal proceedings nor offer legal consultation.

Client Name (Please print):_____

Client/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____