

SOP INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth:	Relationship Status:
Age:	SSN:
# of Dependents:	Gender: M / F
Home/Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Work Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Mailing Address:	
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
EAP Name:	EAP Phone:
Primary Insurance:	ID #:
Group #:	Subscriber Name:
Insurance Phone:	Subscriber DOB:
Emergency Contact Name:	Subscriber SSN:
ER Contact Relationship:	Emergency Contact Phone:
How were you referred?	If online, which website?

Current Concerns:

What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

What kind of obstacles could get in the way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please give dates of treatments and results:

Behavior – circle any of the following behaviors that apply to you:

- | | | | | |
|------------------|---------------------|-------------------|---------------------|----------------------------|
| Overeat | Suicidal attempts | Can't keep a job | Take drugs | Compulsions |
| Insomnia | Vomiting | Smoke | Take too many risks | Odd behavior |
| Withdrawal | Lack of motivation | Drink too much | Nervous tics | Eating problems |
| Work too hard | Procrastination | Sleep disturbance | Crying | Impulsive reactions |
| Phobic avoidance | Outbursts of temper | Loss of control | Aggressive behavior | Concentration difficulties |

Are there any specific behaviors, actions, habits that you would like to change?

Feelings – circle any of the following feelings that apply to you:

- | | | | | | | |
|------------|----------|-----------|-----------|---------|----------|------------|
| Angry | Guilty | Unhappy | Annoyed | Happy | Bored | Sad |
| Conflicted | Restless | Depressed | Regretful | Lonely | Anxious | Hopeless |
| Contented | Fearful | Hopeful | Excited | Panicky | Helpless | Optimistic |
| Energetic | Relaxed | Tense | Envious | Jealous | Others: | |

Physical – circle any of the following symptoms that apply to you:

- | | | | | |
|---------------------|-----------------|--------------------|-----------------------|--------------------------|
| Headaches | Stomach trouble | Skin problems | Dizziness | Tics |
| Dry mouth | Palpitations | Fatigue | Burning or itchy skin | Muscle spasms |
| Twitches | Chest pains | Tension | Back pain | Rapid heart beat |
| Sexual disturbances | Tremors | Unable to relax | Fainting spells | Blackouts |
| Bowel disturbances | Hear things | Excessive sweating | Tingling | Watery eyes |
| Visual disturbances | Numbness | Flushes | Hearing problems | Don't like being touched |

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Aspirin					Insomnia				
Cocaine					Headaches				
Painkillers					Backaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Eat "junk foods"				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive Exercise					High blood pressure				
Use Laxatives					Allergies				