Jessica Irving, MA, LPCC, AT-R

Intake Form

Name: _____

Nickname or preferred name: _____ Birth date: _____

Referred by: _____

Primary Address: _____

Primary Phone Number: _____ OK to leave message? _____

Primary E-mail: _____ OK to e-mail? _____

Background

Goals or hopes for therapy:

_____

_____

_____

Interests, skills, hobbies, strengths: _____

_____

_____

Have you engaged in counseling or therapy before? _____

If so, when/with whom? _____

Medical History

Please describe your overall health/well-being at this time: _____

_____

_____

Are you currently receiving care from any practitioners, therapists, or physicians for any medical conditions or mental health diagnoses? If so, please describe:

_____

_____

Please list any medications, including herbal remedies, you are taking: _____

_____

Have you ever had concerns with any of the following:

____ Disordered Eating ____ Substance Use ____ Abuse/Violence

____ Chronic Medical Conditions ____ Self Harm ____ Suicidal Thoughts/Attempts

Please describe any items checked above:

_____

_____

_____

Family

Please list those who live your home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anything else you would like to share, related to your health and well-being?:

_____

_____

_____

_____