STMC, LLC
Clear Heart Counseling
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stuart@clearheartpdx.com

Individual Intake Form

Please complete this form and bring it with you to your first appointment. The information is to help your counselor understand you and your concerns. If you have any questions or concerns regarding this form, you will have an opportunity to discuss this with your counselor during your session. Your counselor will review your completed form with you in your first few sessions. All information is confidential unless released by written consent except as otherwise required by law.

Today's Date: ___/___/_____

Personal Information

Name: ____ Preferred Name: ____________________________

Date of Birth: ___/___/_____ Age: _____ Gender: _____________ Pronoun: _____________________

Highest Level of Education Completed: ____________________________

Occupation: _______________________________ Employer: _____________________________________

Contact Information

Home Address: ______________________________________ _________________ ____ ____________
City State Zip Code

Mobile Phone: (_____) _____- _____________ May we leave a message? Yes ____ No ____

Work Phone: (_____) _____- _____________ May we leave a message? Yes ____ No ____

Home Phone: (_____) _____- _____________ May we leave a message? Yes ____ No ____

Email: ____

Emergency Contact

Name: _________________________________ Relationship to you: ____________________________

Phone 1: (_____) _____- _____________ Phone 2: (_____) _____- _____________

Your Marital/Relationship Status

□ Single □ Married □ Separated □ Divorced □ Partnered
□ Domestic Partnership □ Widowed □ Other (explain) ____

Your Children

Name: ______________________________ Age: ___ Name: _____________________________ Age: ___

Name: ______________________________ Age: ___ Name: _____________________________ Age: ___

Other People Living in Your Household

Name: ____

Relationship to you: ____

Name: ____

Relationship to you: ____

Risk Assessment

In the last two weeks, have you felt at risk of harming yourself? Y___ N___ Harming others? Y___ N___

If yes, please explain: ____

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In the past, have you felt at risk of harming yourself? Y___ N___ Harming others? Y___ N___

If yes, please explain: ____

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Do you currently experience violence or abuse at home, at work, or in other situations? Y___ N___

If yes, please explain: ____

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Referral Information

How did you hear of our services? ____

Biological Factors

Have you ever been diagnosed with a mental health disorder? Y___ N___

If yes, when were you diagnosed, and what was the diagnosis? ____________________________

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Are you currently under a physician's care for any reason? Y___ N___

If yes, please explain: ____

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Please list any current medications, dosage amounts, and reason for prescription:

____

____

Prescriber Name, Clinic Name and Phone Number:

____

Do you currently use drugs or substances other than the medications listed above?

(e.g. over-the-counter medicine, recreational drugs, alcohol, tobacco, etc.) Y___ N___

If so, please explain what and how often:

____

____

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Have you experienced physical, sexual, or emotional tramatic events? (e.g. being in a serious accident, experienced abuse, witnessing a death). If so, please briefly list date(s) and a short description of trauma(s). Note that we will not go into details in session about a trauma until exploring your feelings about processing them first.

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Your Journey

There is something important about your seeking counseling services at this moment in your life. Please explain why you are seeking counseling now: ____

____

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____

Have you been in therapy or counseling before? Y___ N___

If so, please explain briefly why you sought out counseling in the past, and how it did or did not help you:

____

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____

What do you hope to gain from counseling?

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