Owl Counseling Services, PLLC
Candace Chuyou-Campbell, Ph.D., LPC-S, RPT-S
Adult Client Intake Form

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name:
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Nonbinary □ I prefer not to answer

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Address:
_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____May we email you? □ Yes □ No

Referred by:
_____

Are you currently receiving psychiatric services? □ Yes □ No

If so, please list your psychiatrist: _____

Are you currently seeing another therapist? □ Yes □ No

If so, please give write their name: _____

Please list who you have seen previously for therapy:

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□Yes □No

If Yes, please list all medications and dosages:

If no, have you been previously prescribed psychiatric medication? □Yes □No
If Yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____

3. Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ Other _____

4. How many times per week do you exercise? _____

Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months? □ Yes □ No

6. Do you regularly use alcohol? □ Yes □ No
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes
If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors: _____

_____

Have you ever experienced:
Extreme depressed mood: □ Yes □ No
Wild Mood Swings: □ Yes □ No
Rapid Speech: □ Yes □ No
Extreme Anxiety: □ Yes □ No
Panic Attacks: □ Yes □ No
Phobias: □ Yes □ No
Sleep Disturbances: □ Yes □ No
Hallucinations: □ Yes □ No
Unexplained losses of time: □ Yes □ No
Unexplained memory lapses: □ Yes □ No
Alcohol/Substance Abuse: □ Yes □ No
Frequent Body Complaints: □ Yes □ No
Eating Disorder: □ Yes □ No
Body Image Problems: □ Yes □ No
Repetitive Thoughts (e.g., Obsessions) : □ Yes □ No
Repetitive Behaviors (e.g., Frequent Checking, Handwashing): □ Yes □No
Homicidal Thoughts: □ Yes □ No Last time: _____
Suicide Attempt: □ Yes □ No

OCCUPATIONAL INFORMATION:
Are you currently employed? □ Yes □ No

If yes, who is your current employer/position?

_____

If yes, are you happy at your current position?

_____

Please list any work-related stressors, if any:

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ Yes □ No

If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? □ Yes □ No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Depression: □ Yes □ No _____
Bipolar Disorder: □Yes □No _____
Anxiety Disorders: □ Yes □ No _____
Panic Attacks: □ Yes □ No _____
Schizophrenia: □Yes □No _____
Alcohol/Substance Abuse: □ Yes □ No_____
Eating Disorders: □Yes □No _____
Learning Disabilities: □ Yes □ No _____
Trauma History: □Yes □No _____
Suicide Attempts: □ Yes □ No _____

OTHER INFORMATION:

What do you consider to be your strengths?

_____
_____
_____
_____

What are effective coping strategies that you've learned?

_____
_____
_____

What are your goals for therapy?