Stoner
COUNSELING SERVICES LLC

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StonerCounseling.com

New Client Intake

To help serve you better, bring this completed form to your first appointment.

DATE (mm/dd/yyyy)			
NAME Legal Name (First, Middle Initial, Last)			
NAME You liked to be called	**DATE OF BIRTH** (mm/dd/yyyy)		
MAILING ADDRESS	City	State	Zip
PLACE OF BIRTH City	State	Country	
PHONE/EXT Where can I leave a message for you?	**EMAIL**		

People with whom I can leave a message about your appointments:

NAME First, Last	**RELATIONSHIP**	**PHONE** Ext
NAME First, Last	**RELATIONSHIP**	**PHONE** Ext

Why did you decide to come to counseling/therapy?

What do you want to work on in counseling/therapy? How long has this been a problem?

Are you currently seeing another mental health therapist? ☐ Yes ☐ No

If you had prior counseling experience, how would you describe that experience?

Check the symptoms below that are of concern:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting spells
- ☐ No appetite
- ☐ Over-eating
- ☐ Binge eating
- ☐ Stomach trouble
- ☐ Bowl disturbances
- ☐ Always tired
- ☐ Always sleepy
- ☐ Unable to relax
- ☐ Insomnia (can't sleep)
- ☐ Recurrent dreams
- ☐ Nightmares
- ☐ Hear voices
- ☐ Anger, frustration
- ☐ Chronic health issues
- ☐ Feel interior (to others)
- ☐ Feel tense
- ☐ Feel panicky
- ☐ Fears or phobias
- ☐ Obsessions/compulsions
- ☐ Depressed
- ☐ Suicidal thoughts
- ☐ Prescription drug use
- ☐ Recreational drug use
- ☐ Drinking
- ☐ Allergies
- ☐ Asthma
- ☐ Gender questions/issues
- ☐ Sexual questions/issues
- ☐ Too much/too little energy
- ☐ Spiritual questions/issues
- ☐ Acute health issues
- ☐ Shy
- ☐ Can't make/keep friends
- ☐ Afraid of people
- ☐ Afraid of situations/things
- ☐ Issues at home
- ☐ Unable to have a good time
- ☐ Always worried about something
- ☐ Don't like weekends/vacations
- ☐ Can't make decisions
- ☐ Over-ambitious
- ☐ Financial issues
- ☐ Gambling
- ☐ Job/school/relationship issues
- ☐ Can't keep a job/friends
- ☐ Concentration/memory poor
- ☐ Want more out of life
- ☐ Addiction: _____

Other: _____

Other: _____

Alcohol Consumption

Questions	Never	Monthly or less	2-4 times a month	2-3 times a month	4 or more times a week
1. How often do you have a drink containing alcohol?	◉	○	○	○	○
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	◉	○	○	○	○
3. How often do you have 5 or more drinks on one occasion?	◉	○	○	○	○
4. How often during the last year have you found that you were not able to stop drinking once you had started?	◉	○	○	○	○
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	◉	○	○	○	○
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	◉	○	○	○	○
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	◉	○	○	○	○
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	◉	○	○	○	○
9. Have you or someone else been injured because of your drinking?	◉	○	○	○	○

Current medications, including prescription, over-the-counter, and herbal

NAME	**INDICATION**

Last medical examination

DATE (mm/dd/yyyy)	**REASON**

Are you now under a doctor's care? ☐ Yes ☐ No

Reason for doctor's care:

Anything else that you want to tell us?

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