Blanco Behavioral Health Consulting, LLC

Intake Form

Date: _____

Client Name: _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

Email: _____ Occupation: _____

Race: _____ Permission to leave VM ☐ send text (appointments) ☐ send email ☐

Sexual Identity: Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unsure ☐ Other: _____

Preferred Pronouns: _____ Status: Single ☐ Married/partnership ☐ Separated ☐

Divorced ☐ # ____ Widowed ☐ Never Married ☐

Emergency Contact: _____ Relationship: _____ Phone: _____

Any Disability? Yes ☐ No ☐ (if "Yes," please explain) _____

_____

Suicidal Ideation/Planning? Yes ☐ No ☐ (if "Yes," please explain)

_____

Psychiatric Diagnosis? Yes ☐ No ☐ (if "Yes," please explain)

_____

Medical Conditions? Yes ☐ No ☐ (if "Yes," please list them)

_____

Any Medications? Yes ☐ No ☐ (if "Yes," please list them)

_____

Spouse/Partner (couple therapy): _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

Email: _____ Occupation: _____

Race: _____ Permission to leave VM ☐ send text (appointments) ☐ send email ☐

Sexual Identity: Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unsure ☐ Other: _____

Blanco Behavioral Health Consulting, LLC

Preferred Pronouns: _____ Status: Single ☐ Married/partnership ☐ Separated ☐

Divorced ☐ # ____ Widowed ☐ Never Married ☐

Emergency Contact: _____ Relationship: _____ Phone: _____

Any Disability? Yes ☐ No ☐ (if "Yes," please explain) _____

_____

Suicidal Ideation/Planning? Yes ☐ No ☐ (if "Yes," please explain)

_____

Psychiatric Diagnosis? Yes ☐ No ☐ (if "Yes," please explain)

_____

Medical Conditions? Yes ☐ No ☐ (if "Yes," please list them)

_____

Any Medications? Yes ☐ No ☐ (if "Yes," please list them)

_____

Children: Yes ☐ No ☐ (if "Yes," list children's information below)

Name	Date of Birth	Gender	Custody/Adult

List the Primary Care Physicians for Individual Client, Partner (if applicable), **Children**

Name	Address	Phone

Reason you're seeking counseling at this time:

_____

_____

Any symptoms of psychological distress:

_____

Have you been in counseling before? Yes ☐ No ☐ (if "Yes," was it helpful?) _____

Who did you grow up with? _____ Siblings # Closest to: _____

Childhood adversities? Yes ☐ No ☐ (if "Yes," please explain)

_____

Coping mechanisms/tendencies:

_____

Social support:

_____

Spirituality? Yes ☐ No ☐ (if "Yes," please explain)

_____

Anything else you want the counselor to know:

_____

_____

Signature: _____