Exit Right, LLC

"You won't leave the same way you came"

10226 Curry Road. #107- PMB# 13
Orlando Florida 32825
(407) 391-1245

CONFIDENTIAL INTAKE FORM

Full Name: _____ Date: _____

GENERAL INFORMATION

Street Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth ____/____/_____

Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other Sex: [ ] Male [ ] Female

Email Address: _____

Phone (h): _____ May we contact you here? [ ] Yes [ ] No

Phone (c): _____ May we contact you here? [ ] Yes [ ] No

Phone (w): _____ May we contact you here? [ ] Yes [ ] No

May we leave a message for you? [ ] Yes [ ] No May we text you? [ ] Yes [ ] No

Occupation:_____ Place of Employment/School:_____

Education Level: [ ] High School; [ ] Some College; [ ] Bachelors Degree; [ ] Graduate School

Hours worked per week: _____ Estimated annual income: _____

How did you hear about us? [ ] Internet [ ] Physician [ ] Friend [ ] Parent [ ] Other

Name of person who referred you: _____

May we thank them for referring you? [ ] Yes [ ] No

What type of counseling are you seeking? Please choose one and note Forms Required.

Type	**Description**	**Forms Required**
[ ] Individual	One-on-One Counseling	1 Intake Form per person
[ ] Family	Two or more family members	1 Intake Form per person over 18 yrs.
[ ] Relationship	Dating couples	1 Intake Form per person (2 total)
[ ] Pre-Marital	Engaged couples or those considering marriage	1 Intake Form per person (2 total)
[ ] Marital	Couples needing marital guidance	1 Intake Form per person (2 total)

RELATIONAL INFORMATION

Current relational status: [ ] Single [ ] Dating [ ] Engaged [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Are you content with your current relational status: [ ] Yes [ ] No (if no, briefly explain):_____

_____

_____

If married, how long:_____ Number of marriages for you: _____ For your partner: _____

If separated or divorced, how long: _____ If widowed, how long: _____

Partner's Name: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. [ ] Rev. _____

How long have you known your partner: _____ Their age: _____ Preferred name: _____

Partner's Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other Partner's sex: [ ] Male [ ] Female

Partner's Occupation: _____ Hours worked per week: _____

Partner's Education Level: [ ] High school [ ] Some college [ ] Bachelors degree [ ] Graduate school

What words would you use to describe your partner?

_____

Is your partner supportive of you seeking counseling? [ ] Yes [ ] No [ ] Unsure [ ] Partner doesn't know

List your children below (including step, adopted, foster):

Name	Sex	Age or year of death	Relationship to you	Living with you

Have you ever placed a child for adoption? [ ] Yes [ ] No If yes, when? _____

Have you ever had a miscarriage or medical abortion? [ ] Yes [ ] No If yes, when? _____

List your mother, father, brothers, sisters, stepfamily relations, or any other family member who had a significant effect (positive or negative) upon your life:

Name	Age or year of death	Relationship to you	Describe this person

PHYSIOLOGICAL INFORMATION

Describe your current health: [ ] Good [ ] Fair [ ] Poor Date of your last physical exam: ____/____/_____

List any medical conditions, illnesses, treatments, or surgeries: _____

_____

Check any of the following symptoms/sensations that apply to you presently, or in the recent past:

Headaches [ ] Past [ ] Present Dizziness [ ] Past [ ] Present Stomach Trouble [ ] Past [ ] Present

Visual Trouble [ ] Past [ ] Present Sleep Trouble [ ] Past [ ] Present Trouble Relaxing [ ] Past [ ] Present

Weakness [ ] Past [ ] Present Tension [ ] Past [ ] Present Rapid Heart Rate [ ] Past [ ] Present

Difficulty Breathing [ ] Past [ ] Present Intestinal Trouble [ ] Past [ ] Present Hearing Noises [ ] Past [ ] Present

Change in Appetite [ ] Past [ ] Present Tiredness [ ] Past [ ] Present Pain [ ] Past [ ] Present

Hearing Voices [ ] Past [ ] Present Seeing Things [ ] Past [ ] Present Other [ ] Past [ ] Present

Height: _____ Weight: _____ Weight change in the last 2-3 months: _____

List all current medications you are taking, including those you seldom use or take only as needed:

Name of Medication(s)	Dosage	Reason for taking them

Are you presently experiencing suicidal thoughts? [ ] Yes [ ] No

Have you experienced them in the past? [ ] Yes [ ] No

Have you ever attempted suicide? [ ] Yes [ ] No If yes, when and how?_____

Have any friends or family committed suicide? [ ] Yes [ ] No If yes, when and how?_____

Are you presently experiencing any thoughts of harming another person? [ ] Yes [ ] No

COUNSELING HISTORY

List names of previous counselors, therapists, or mental health programs, including dates and contact information:

_____

_____

How do you feel about the results of your previous counseling?

_____

Do we have permission to contact your previous counselor(s)? [ ] Yes [ ] No

Have you ever been hospitalized for psychiatric purposes? [ ] Yes [ ] No

If yes, please explain including name of hospital, location, and dates: _____

_____

RELIGIOUS BACKGROUND (optional)

Do you believe in God? [ ] Yes [ ] No Religious preference: _____

Which church do you currently attend?_____

How much influence does your religion have on your day-to-day activity? [ ] Very little [ ] Some [ ] A lot

REASON FOR SEEKING HELP

What concerns have led you to pursue counseling? _____

_____

Where are your concerns causing the most problems for you? Check all that apply.
[ ] Home [ ] Work [ ] Marriage [ ] God [ ] Other Relationships (specify): _____

When did your present concern begin to become a problem for you? _____

_____

Check any of symptoms or problems that you are currently experiencing. ***Check all that apply***.

[ ] Stress
[ ] Anxiety or worry
[ ] Fatigue/Lack of energy
[ ] Poor appetite or overeating
[ ] Trouble sleeping
[ ] Physical abuse
[ ] Feeling worthless or inferior
[ ] Verbal abuse
[ ] Sexual abuse
[ ] Sexual problems
[ ] Gender Identity
[ ] Anger
[ ] Aggressive behavior
[ ] Bad dreams
[ ] Unwanted memories
[ ] Loss of control
[ ] Impulsive behavior
[ ] Controlling
[ ] Controlled by others
[ ] Obsessive thoughts

[ ] Panic
[ ] Depression
[ ] Marital Problems
[ ] Other relational problems
[ ] Parenting problems
[ ] Hearing voices
[ ] Emotional abuse
[ ] Eating problems
[ ] Drug use
[ ] Alcohol abuse
[ ] Pregnancy
[ ] Abortion
[ ] Legal Matters
[ ] Work Stress
[ ] Career choices
[ ] Indecisiveness
[ ] Lack of discipline
[ ] Financial Problems
[ ] Spiritual apathy
[ ] Other: _____

[ ] Crying all the time
[ ] Lack of motivation
[ ] Compulsive behaviors
[ ] Seeing things others don't see
[ ] Poor concentration
[ ] Racing thoughts
[ ] Feeling hopeless
[ ] Guilt
[ ] Death of friend or loved one
[ ] Grief
[ ] Chronic Pain
[ ] Physical disability
[ ] Terminal illness
[ ] Health concerns
[ ] Loneliness
[ ] Fears
[ ] Shyness
[ ] Low self esteem
[ ] Don't like myself
[ ] Other: _____

Have any concerns about you been identified by others? _____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Minimally Distressing	**Moderately Distressing**	**Extremely Distressing**

What do you hope to gain or change by coming to counseling at this time?

_____

_____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____