STANDARD INTAKE QUESTIONNAIRE

This questionnaire requests information about you and your treatment needs. Please take a few moments to complete the form. If the person seeking care is a minor, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them during our session. Thank you for choosing Core Counseling Services and I look forward to working with you to help you achieve your treatment goals.

Client Name: _____

Preferred pronouns: _____

Today's Date: _____ Date of Birth: _____

E-Mail Address: _____

Street Address: _____

City/State/Zip Code: _____

Best Contact Phone #: _____ Alternate #: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ E-Mail

How would you describe yourself: ☐ American Indian or Alaskan Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Biracial ☐ Multiracial

☐ Rather not say

Emergency Contact Name: _____

Phone: _____ Email Address: _____

Who referred you to our practice (Name, Specialty, & Phone)?

_____

9475 Deereco Road., Suite 410 Timonium, MD 21093 | 410.560.6135 | www.corecounselingservices.net

Insurance Information:

Policy Holder: _____ Relationship: _____

Policy Holder's Social Security #: _____ Date of Birth: _____

Insurance Company: _____

Member ID: _____ Group #: _____

Relationship Status: ☐ Single ☐ Married ☐ Re-Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Domestic Partner

Job Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Other: _____

Name of Employer and/or School: _____

Occupation: _____

Education (last year completed): ☐ No Formal Schooling ☐ Middle School (Grade: _____)
☐ High School/GED (Grade: ____) ☐ College (Years: _____) ☐ Graduate School (Years:___)

Do you have any children? ☐ Yes ☐ No

If yes, please list birthdates and gender: _____

_____

Please list the people living in your household and their relationship to you: _____

_____

Date of last physical examination: _____

Please list any medications and/or supplements you are currently taking:

Medication	Condition	Dosage (mg)	Frequency	Approximate Start Date

Prescriber's Name: _____
Phone: _____

Primary Care Physician's Name:_____
Phone: _____

May we contact your doctors? ☐ Yes ☐ No

Previous Mental Health Treatment (within past 2-years): ☐ Yes ☐ No

If yes, please provide the following:

Check all that apply: ☐Psychiatrist ☐ Psychologist ☐ LCPC/LCSW-C ☐ School Counselor
☐ Other: _____

Mental Health Provider's Name: _____

Phone: _____

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you have suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Do you have thoughts or urges to harm others? ☐ Yes ☐ No

Have you ever been hospitalized for a psychiatric issue? ☐ Yes ☐ No

Is there a history of mental illness in your family? ☐ Yes ☐ No

Please check any of the following you have experienced in the past six months:

☐ Increased appetite ☐ Decreased appetite ☐ Trouble concentrating ☐ Difficulty sleeping
☐ Excessive sleep ☐ Low motivation ☐ Isolation from others ☐ Fatigue/Low energy
☐ Low self-esteem ☐ Depressed mood ☐ Tearful or crying spells ☐ Anxiety ☐ Fear
☐ Hopelessness ☐ Panic ☐ Other: _____

What brings you to counseling at this time? Is there something specific, such as a particular event?: _____

_____

_____

_____

What results do you hope to obtain from counseling? What are your goals?_____

_____

_____

_____

Please list any current medical problems: _____

_____

_____

_____

Is there anything else that might be important for me to know? _____

_____

_____

_____

_____

Credit Card Easy-Pay Consent & Payment Policy

We require that you provide us with a valid credit card number to keep on file. Please provide the following information to be kept in your confidential and secure file:

Credit Card Holder's Name (as it appears on the card): _____

Card Holder's Social Security #_____

I authorize Core Counseling Services to charge my credit card for balances due including copayments/deductible and missed appointment fees to be charged after each visit.

Credit Card Number: _____

Expiration Date: _____

Security Code on the back of the card: _____

Billing Zip Code: _____

Please check one: ☐ Visa ☐ Mastercard ☐ Discover ☐American Express ☐ HSA

Card Holder's Signature: _____

Date: _____

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