

Orlando Counseling Specialists

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Welcome

Please fill out the following information. In this packet, you will have an Intake form and an Informed Consent Form to fill out and sign. You will also find Office Policies and Procedures and the Notice of Privacy to be read carefully. The final page in a signature page indicating that you have read the Notice of Privacy and have read and agreed to the Office Procedures and Policies.

Date: _____

Date of Birth: _____

Name: _____
first middle last

Address: _____
street city state zip code

Phone: _____
home work cell

Employer: _____

Current Marital Status: ___ *married* ___ *single* ___ *divorced* ___ *engaged* ___ *widowed*

Husband's Name: _____ Employer: _____

Children: (*names and ages*) _____

Family Physician: _____

Phone number: _____

Psychiatrist: _____

Phone number: _____

1. Current Medications _____

2. Are you now or have you ever experienced suicidal thoughts? _____ If yes, when? _____

3. Are you now or have you ever experienced homicidal thoughts? _____ If yes, when? _____

4. Hospitalizations: (*include dates and reasons as they relate to mental illness*) _____

5. Have you seen a mental health professional in the past? _____ When and with whom? _____

6. Can you briefly describe the reason for your visit? _____

7. What do you hope to gain from this counseling experience? _____

8. What else would you like me to know? _____