BIRCH COUNSELING
Growth.Hope.Resilience.

Intake Form

Responsible Party's Name:___________________ Client DOB:______________________

Relationship to Client (if minor):_______________ Client Gender:____________________

Client Name (if minor): _____________________

Client Pronouns: __________________________

How did you hear about Birch Counseling?
____

Address:
- Street:
- Street 2:
- City:
- State:
- Zip:

Phone Number:
- Home:
- Cell:
- Work:

Email:

Insurance Information

Primary Insurance:
- Plan Number:
- Group Number:

Secondary Insurance:
- Plan Number:
- Group Number:

Policy Holder's Date of Birth:_____________

Do I have permission to send mail to the address you entered above? Yes ☐ No☐

Do I have permission to text you at the mobile number listed above? Yes ☐ No☐

Would you like to receive text reminders for appointments? Yes ☐ No☐

Do I have permission to send email to the address you entered above? Yes ☐ No☐

Dependents and Any Other Household Members (Please include all children. For minor children, indicate who they live with if they do not reside with you).

Name	Relationship	Place of Residence	Age

Medical and Health History

List any allergies you have:

Primary Care Physician:

Address:
City:
State:
Zip:

Phone Number:
Date of last physical:

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

List all therapists you have seen in the past 5 years, diagnosis received, and approximate dates you saw them:

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

Please indicate which of these substances you currently use:

Substance	Amount Used	How Often
Cigarettes		
Alcohol		
Marijuana		
Pills not prescribed for me		
Cocaine or crack		
LSD		
Heroin		
Other:Click here to enter text.		

Please list all current or past health problems, and any major operations:

Please indicate if you are having any of the following problems, or if you had them in the past:

Problem	I have this now	I had this in the past (over 6 months ago)
Difficulty Falling or Staying Asleep	☐	☐
Sleeping too much	☐	☐
Change in appetite, weight loss, weight gain	☐	☐
Frequent crying	☐	☐
Panic attacks/anxiety attacks	☐	☐
Thoughts of killing myself	☐	☐
Attempts to kill myself	☐	☐
Problems concentrating	☐	☐
Problems remembering things	☐	☐
Daily sadness	☐	☐
I startle easy	☐	☐
Can't stop remembering upsetting past events	☐	☐
Nightmares	☐	☐
Aggression towards people	☐	☐
Aggression towards animals	☐	☐
I break things sometimes	☐	☐
I worry a lot	☐	☐
Little interest in normal activities	☐	☐
I feel tired most of the time	☐	☐
Feelings of unreality	☐	☐
Use laxatives or excessive exercise to lose weight	☐	☐
I feel like I am an outsider	☐	☐
Sexual problems	☐	☐
I worry something is wrong with my body	☐	☐

Frequent arguments	☐	☐
I hear voices other’s don’t hear	☐	☐
I see things other’s don’t see	☐	☐
I cause physical harm to myself	☐	☐
Excessive Daydreaming or zoning out	☐	☐
I act impulsively often	☐	☐
Bedwetting or Enuresis	☐	☐
Encopresis	☐	☐
Frequent headaches, stomachaches, or muscle aches	☐	☐
Attachment Difficulties (i.e. problems forming safe, trusting relationships with a dults)	☐	☐
Developmental Delays	☐	☐

Please take your time and describe what brings you to Birch Counseling?