UTHSC COUNSELING SERVICES – INTAKE FORM

First and Last Name:		
Preferred Name:	Age:	DOB:
Address:		
Cell/Home Number:	Work Number:	
Permission to leave message at cell/home number? ☐ Y ☐ N	Permission to leave message at work number? ☐ Y ☐N	
Preferred way to be contacted: ☐Cell/Home ☐Work ☐ Email ____		
Email correspondence is not considered to be a confidential medium of communication.		
In case of an emergency, whom may I contact?		
Relationship to you:	Phone Number:	

Gender Identity (M, F, Trans, Other):	Race/Ethnicity:
Sexual Identity/Orientation:	
Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ____________	
Rate Relationship Satisfaction. (Very Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (Very Satisfied) _______	
Current Partner's Name:	Length of Relationship:

College:	Program:	Grad. Year:
College/Graduate degree? ☐ Y ☐ N	Field of Study:	
Are you employed? ☐ Y ☐ N	Employer:	
Average hours worked per week:		

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Family of Origin: List parents, siblings, step family, and any other significant family members.
If person is deceased put an "X" in the age box and indicate date of death.

First Name	Age	Relationship	City, State	Substance Abuse History	Suicidality History	Psychiatric History
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Do you have children? (List all children, including biological, adopted, foster, and step children)

Name	Age	Relationship	City, State	Resides with you?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Have you ever received or given abuse? ☐ Y ☐ N	If yes, ☐ Physical ☐ Emotional/Verbal ☐ Sexual ☐ Neglect ☐ Other:
Do you have an order of protection? ☐ Y ☐ N	Do you feel unsafe in your relationship? ☐ Y ☐ N
Do you have stable housing? ☐ Y ☐ N	

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Primary Care Physician's Name:
Psychiatric Medical Provider's Name:

Illness/Disability: List chronic/significant illnesses, disabilities, or medical conditions.	Date(s) of Diagnosis

List all medications being taken (prescribed, OTC, supplements, etc.)	Dosage	Treating
Are you compliant with instructions for medications use? ☐ Y ☐ N If No, briefly explain:		

Describe your spiritual or religious beliefs. Is it important to incorporate these beliefs into therapy? ☐ Y ☐ N
List significant life changes or stressful events experienced recently.

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Rate your current sleep habits. (Circle one) (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
If rated less than "5", briefly explain:	Average number of sleep hours per night: _______ For how long? _____________
Frequency of exercise per week _______ Type of activity ______________________________ Duration ____________	
Rate your current diet/nutritional habits. (Circle one) (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)	
If rated less than "5", briefly explain:	History of Disordered Eating? ☐ Y ☐ N
List current self-care behaviors/ hobbies/interests that you engage in and frequency per week:	

Do you drink alcoholic beverages? ☐ Y ☐ N	If yes, how many daily or weekly? ____
Do you have a problem with alcohol? ☐ Y ☐ N	Who believes you have a problem with alcohol?
Do you smoke or vape? ☐ Y ☐ N	If yes, list what and quantity/frequency of use per day/week.
Have you in the past or currently, used or abused illicit substances or illegally obtained substances? ☐ Y ☐ N ***	
***Note: Use of illicit substances or illegally obtained substances during clinical care training must be reported. ***	
At what age did you begin using alcohol? ____ smoking/vaping? _____ other ______ Have you ever tried to quit? ☐ Y ☐ N If yes, briefly explain:	
Previous substance use/abuse treatment? ☐ Y ☐ N	If yes, briefly describe:

Do you currently think of killing yourself? ☐ Y ☐ N (List frequency, intensity and duration)
If "yes" currently, do you have a plan? ☐ Y ☐ N Intent? ☐ Y ☐ N Access to Means? ☐ Y ☐ N
In the past, have you thought to kill yourself? ☐ Y ☐ N
If "yes", list frequency, intensity, duration and dates:
Have you ever attempted to kill yourself? ☐ Y ☐ N

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If yes, list "Number of attempts" _____ Age of 1st attempt ______ Age of most recent attempt _______
Do you currently or have you in the past hurt yourself i.e. cutting, burning, etc.? ☐ Y ☐ N
If "yes", list method, duration and frequency.
Have you ever had a psychiatric hospitalization? ☐ Y ☐ N
If yes, describe briefly and indicate dates:
Have you experienced one or more traumatic events in your life (either personally or vicariously)? ☐ Y ☐ N
If yes, and if you are comfortable, describe briefly and indicate dates:

Are you currently seeing another therapist? ☐ Y ☐ N			
If yes, please indicate the therapist's name:			
Have you ever been in therapy in the past? ☐ Y ☐ N			
If yes, please fill out the following on your previous counseling experience(s):			
Therapist	Location	Dates	Reason for therapy

Briefly describe your reason(s) for seeking therapy at this time: What do you wish to accomplish during the therapy process?

How were you referred? ☐ Self ☐ Website ☐ Program ☐ Faculty ☐ Other ___________