Dr. Corey Gilbert, PhD, LPC, PA-ABCST, CFTP
Professional Counseling, Coaching & Speaking Services
HealingLives, LLC

Intake Form

(confidential)

Name ________________________________ **Date** ______________ **Cell Phone** _________________________

Address ____ **Work Phone** ____________________

City / State / Zip _________________________________

May we call you and leave a message at these numbers? **Home**: Y N **Work**: Y N

Email ____

Marital Status (Circle): Single / Married / Separated / Divorced / Widowed / Cohabitating
Number of Marriages ________ **Date of Birth** _____________ **Gender** ________

Emergency Contact: Name _______________________ **Relationship** ______________ **Cell** __________________

Concerns Bringing You to Counseling (summarize briefly in one or two phrases)

____

____

Whose idea was it for you to come to counseling? ____

Please rate the severity of your present concerns on the following scale:
Mild Moderate Severe Totally Incapacitating

Have you EVER experienced any of these life crises (past or present)?

____Death of Significant Other ____Drug Use ____Childhood Neglect
____Loss of Job ____Divorce/Separation ____Verbal Abuse
____Serious Illness ____Divorce of Parents ____Foster Care
____Pregnancy ____Physical Abuse ____Frequent Moving
____Others: ____

Check any of the following that apply to you TODAY:

____Fear ____Loss of Control ____Depression ____Anxiety/Nervousness
____Shame/Guilt ____Alcohol/Drug Use ____Disturbed Sleep ____Nightmares
____Anger ____Eating Disorders ____Offending Behavior ____Self-Esteem/Confidence
____Worry ____Suicidal Thoughts ____Sexual Problems
____Denial ____Physical Self Harm ____Problems with Relationships
____Others: ____

Sexual Abuse Questions **(Please skip if not applicable)**
If you are a victim of sexual abuse (includes incest, molestation, or rape), please answer the following questions:
Single Offense_____ Multiple Offenses_____ Date(s) of Offense(s) ____________________
Age when abuse began _____ Age at last known offense _____
If Multiple Offenses, how long did abuse occur? _______ Same Offender or Different _____
Have you told anyone of the abuse? Yes No If yes, how old were you? _____
Was medical attention sought? Yes No Was the assault reported to the authorities? Yes No
Did you become pregnant? Yes No

When did you accept Christ as your Savior? ________ Attend a local church? Where? _______________
At some time during our sessions when a natural opportunity arises, would you be open to learning how Jesus Christ can be included in your healing process? **Yes No We'll See**

Additional Information

Job Title ____ **Employer** _____________________________________

Who Referred you to Counseling? _______________________________________ **Referral Date** _________________

How did you find me? ____

Is there a history of any of the following? (please check all that apply)

____Suicide
____Major Depression
____Anxiety
____Domestic Violence
____Drug or Alcohol Abuse (self or family)
____ADD / ADHD
____Grief Issues
____Sexual Abuse
____Contact with Child Protective Services or similar agency
____Other: ____

Have you had any previous counseling? ________ If so, where and when and with regard to what issues?

Name of previous therapist _________________________________ Address ___________________________________

Dates of therapy? From _____________ To ______________ City ________________ State/Zip _________________

Issues of Concern Previously: ____

Reason for Termination of Therapy: ____

Medical History
Current Medications ____

Check the behaviors and symptoms that occur to you more often than you like them to take place:

____Aggressions
____Alcohol dependence
____Anger
____Antisocial behavior
____Anxiety
____Avoiding people
____Chest pain
____Cutting
____Depression
____Disorientation
____Distractibility
____Dizziness
____Drug dependence
____Eating disorder
____Elevated mood
____fatigue
____hallucinations
____heart palpitations
____high blood pressure
____hopelessness
____impulsivity
____irritability
____judgment errors
____loneliness
____memory impairment
____mood shifts
____panic attacks
____phobias / fears
____recurring thoughts
____sexual difficulties
____sick often
____sleeping problems
____speech problems
____suicidal thoughts
____thoughts disorganized
____trembling
____withdrawing
____worrying
____other (specify)
____
____
____

List additional illness, physical conditions or complaints:

____

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CREDIT CARD INFORMATION

Providing credit card information is *optional*. Credit card information will be kept on file and used as a backup payment for your therapy sessions. Other forms of payment include cash and check.

Name on Card:

____

Card Number:

____

3-digit verification code (back of card) Exp.

____

Circle One: Visa MasterCard

"By signing below, I authorize my credit card to remain on file and used for the purposes of counseling services with Dr. Corey Gilbert for the below patient. Should I fail to give 24-hour cancellation notice, this card may be used without notice as payment for the late cancelled session."

Cardholder Printed Name:

____

Cardholder Signed Name:

____

Client Printed Name:

____

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