Healthy Sexual Solutions

Healthy Sexual Solutions
Intake Form

CLIENT INORMATION

Name _____

Mailing Address _____

Telephone Number _____

E-Mail Address _____

BIOGRAPHICAL INFORMATION

Date of Birth _____

Occupation _____

Marital/Relationship Status _____

Family/Children Status _____

Gender Identity _____

Race/Ethnicity _____

Religion _____

PRESENTING ISSUE

What are your current concerns or reasons for seeking our services?

_____

_____

REFERRAL INFORMATION

Referred/sanctioned? No _____ Yes _____

If yes, by whom? _____

PERSONAL HISTORY

Previous counseling or therapy experience?	No _____	Yes _____
Emotional symptoms or concerns?	No _____	Yes _____
Anxiety, panic or nervousness?	No _____	Yes _____
Sadness or depression?	No _____	Yes _____
Family or relationship problems?	No _____	Yes _____
Questions about sexual identity or sexual orientation?	No _____	Yes _____
Eating disorder?	No _____	Yes _____
Sleep problems?	No _____	Yes _____
Drug, alcohol, or substance abuse?	No _____	Yes _____
Psychiatric hospitalization?	No _____	Yes _____
Serious surgery, illness or injury?	No _____	Yes _____

EMERGENCY CONTACT INFORMATION

Name _____

Telephone Number _____ Relationship _____

SIGNATURE

Name _____ Date _____