Lola Georg, MS
Licensed Professional Counselor
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484-324-8370 (phone or text)

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Pronouns: _____ Relationship Status: _____

Please list any children and their ages: _____

_____

Address: _____

_____

Referred by: _____

Preferred Phone: _____
May we leave a voice message? ☐Yes ☐No May we leave a text message? ☐Yes ☐No

E-mail: _____
May we email you? ☐Yes ☐No

Please note: Text, phone and email communications are not considered to be a confidential forms of communication.

Emergency Contact Person: _____

Relationship to you: _____

Phone Number: _____

Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services, etc.)? ☐ No ☐ Yes, previous counselor/practitioner(s):

_____

Are you currently taking any prescription psychiatric medication? ☐ Yes ☐ No

Please list medication(s) and dosage(s):

_____

_____

Who prescribes your psychiatric medication?

_____

Are you currently taking any other prescription medication? ☐ Yes ☐ No

Please list medication(s) and dosage (s):

_____

_____

GENERAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health challenges you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes - If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes - If yes, when did you begin experiencing this? _____

Are you experiencing any chronic pain?

□ No □ Yes - If yes, please describe? _____

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use? □ Daily □ Weekly □ Infrequently □ Not at all

Are you currently in romantic relationship(s)?

□ No □ Yes - If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship(s)? _____

What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (parent, grandparent, sibling, etc.).

Alcohol/Substance Abuse _____

Anxiety _____

Depression _____

Domestic Violence _____

Bipolar Disorder _____

Eating Disorders _____

Suicide Attempts _____

Schizophrenia _____

ADDITIONAL INFORMATION

Are you currently employed? □ No □ Yes - If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious?

□ No □ Yes If yes, describe your faith or belief:_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weakness?

_____

_____

What would you like to accomplish during your time in counseling?

_____

_____

Do you have any questions about counseling?

_____