Kristin Carswell, LPCS
383 Merrimon Avenue
Asheville, NC 28801

Counseling Intake

Legal name______________________________ DOB & Age_____________________
Preferred/chosen name____________________________Pronoun preference__________
Address: ____
Phone Number________________________ O.K to call/Leave Message?_____________
Emergency Contact_____________________ Relationship to you? ________________
Emergency Contact Number______________ Referred by: _________________________
Please describe why you are seeking counseling at this time:_____________________
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____

Are you working with any other mental health care providers including psychiatrists? If so, please list.____
____
Current Medications: ____
____
Past psychiatric medications: ____
Previous mental health diagnosis?____
____
Health insurance information if applicable: ___________________________________
____

SYMPTOM CHECKLIST

Anxiety Symptoms: *Please circle all that apply:* Worry/ Fears/ Restlessness/ Poor Appetite/ Insomnia/ Dreams-Nightmares/ Flashbacks/ Panic Attacks/ Repetitive Thoughts- Actions/ Mind Races/ Afraid to: go outside – be in public places – be around people/ Other_______________________________
Comments: ____
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Emotions: *Please circle all that apply:* Change quickly/ Hard to control/ Crying Daily/ Numb/ Multiple ups & downs during week/ Affecting functioning or relationships/ Other ___________________
*Comments:*____

Depression Symptoms: *Please circle all that apply:* Unhappy/ Irritable / Moody/ Low Motivation/ Guilt feelings/ Sadness/ Hopelessness/ Overwhelmed/ Grieving/ Insomnia/ Excessive Sleep/ Tired all the time/ Crying Excessively/ Loss of interest in previous activities/ Low self esteem/ Withdrawing/ Poor Concentration/Isolation/ Change in Appetite/ Weight gain or loss/Other________________________

*Comments:*____

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Self Control: *Please circle all that apply:* Poor Impulse Control/ Outbursts/ Acting out to hurt others/ Overeating/ Too active/ Sexually acting out/ Temper Tantrums/ Other ____________________________
Comments: ____

Relationships with Others: *Please circle all that apply:* Have trouble communicating/ Unassertive/ Too assertive/ Problems "getting along"/ Not enough relationships/ Unsatisfied with current relationships/ Can't maintain friendships/ Have positive supportive relationships/ Satisfied with current relationships/ Able to sustain long term relationships/ Other ____
Comments: ____

Do you have concerns about your sexual health? Please describe. ________________________

____

Please list three or more events that have positively impacted your life

____

____

____

Please list three or more events that have negatively impacted your life

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Suicidal Thoughts: *Please circle all that apply:* No current thoughts/ No history of suicidal thoughts/ Current thoughts/ Recent suicidal thoughts/ Past suicidal thoughts/ No current plan/ Current plan (Describe)____

____

Past plan or attempt/ ____
History of Self Harm? ____

____

History of family suicide/ Have experienced recent suicide of friend-family/ Other __________________
*Comments:*____
History of Substance Use/Abuse: *Please describe:* _______________________________________
___________________________________*Treatment?*____

____

Are you concerned about your use of substances? _______________________________
Please rate your sleep habits: Poor/Unsatisfactory/Satisfactory/Good/Very good
What do you want to accomplish through counseling? ___________________________

____

____

What strengths do you possess that will help you accomplish this? _______________

____

____

How will you know when things are better? ___________________________________

____

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Please attach additional sheet of paper if necessary.