COUNSELING INTAKE FORM

CONFIDENTIAL

George A. Buettner, M.A., *Licensed Professional Counselor,*
Board Certified Professional Christian Counselor

PERSONAL

First Name ______ Last Name ______ Spouse's Name ______ Your Date of Birth ______

Street Address ______ Apt. # ______ Email address ______

Zip Code ______ City/Town ______ State ______

Home Phone ______ Work Phone ______ Cell Phone ______

REASON FOR COUNSELING

☐ Alcohol Issues ☐ Anxiety Issues ☐ Depression Issues ☐ Personal Crisis ☐ Other

☐ Drug Abuse Issues ☐ Marriage Crisis ☐ Moral and Religious Issues ☐ Premarital Counseling ________________

Circle Appropriate: Divorced (Date ______) Married (Date ______) Separated (Date ______) Single Widowed (Date ______)

Children:

Name	Relationship	Birth Year

Previous Counseling Events:

☐ Alcohol In-patient Treatment ☐ Alcohol Out-patient Treatment ☐ Alcoholics Anonymous ☐ Hospitalized for Psychosis

☐ Domestic Violence ☐ Drug Abuse In-patient Treatment ☐ Drug Abuse Out-patient Treatment ☐ Hosp. for Suicide Attempt

☐ Hospitalized for Anxiety Disorder ☐ Hospitalized for Depression ☐ Hospitalized for Nervous Breakdown ☐ Suicide Attempt

LEGAL EVENTS

☐ Felony Arrest ☐ Felony Conviction ☐ Jail Time ☐ Legal Action ☐ Misdemeanor Arrest ☐ Misdemeanor Conviction

☐ Police Action ☐ Prison Time ☐ Other____

MEDICAL EVENTS

○ Heart Attack ○ Cancer, full remission ○ Obesity (20% overweight) ○ Gastrointestinal issues

○ Heart disease ○ Cancer, non-terminal ○ Hypertension ○ Stroke

○ Congestive heart failure ○ Cancer, terminal ○ Stomach ulcers

○ Diabetes ○ Seizure disorder ○ Colitis

Other condition(s) ______

Briefly, why are you here today?____

____

(Please turn page and continue)

Who referred you?____

Your Physician_________________________________Office Phone Number_______________________________

List medications you take regularly____

Have you recently (past 2 years) seen a mental health professional? (   ) Yes (   ) No   Name_________________________

Please feel free to ask questions about any of the following:

I have read the professional disclosure statement and understand my rights as a consumer of counseling services in the State of Oregon. I understand the limitations on confidentiality. (   ) Yes (   ) No

By signing this form, I indicate that I am seeking professional mental health services and that I understand my rights and obligations under Oregon Law (the right to confidentiality and the right to professional services which meet basic standards set by law).

(   ) Personal Payment   (   ) Insurance   *Rate: $35.00 per 60 min. session ($7.50 per 15 min. thereafter)*

Signed____Date_________________________

Rev. 12/97, 6/06, 7/10