Wes Cauthers, M.A., LMHC

Intake Form

Date _____

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Other Phone _____

Sex (M/F) ____ Date of Birth _____

Is it acceptable to contact you at home? Y / N
If "no" then how can I contact you? _____

Are you currently under medical care? Y / N
If yes, then please explain/describe. _____

_____

Name of Personal Physician & Phone Number: _____

Are you currently taking prescribed medications? Y / N
If yes, then please explain/describe. _____

_____

List any psychiatric/mental health medications you have taken. _____

_____

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem which required attention. _____

_____

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders
Sexual Problems	Suicidal Thoughts	Separation/Divorce	Relationships
Finances	Drug/Alcohol Use	Career Choices	Anger
Self-Control	Unhappiness	Insomnia	Religious Matters
Work/Stress	Health Problems	Cutting/Self-Mutilation	Thought Patterns