Bridges of Hope Counseling

Where hope and healing meet.

License: Licensed Professional Counselor OH

INTAKE FORM

Client Name:

Date/Time:

Please fill out all the areas.

Name: **(required)**

If client is a minor, name of guardian(s): **(required)**

Address **(required)**

City, State, Zip: **(required)**

Home Phone: **(required)**

Cell Phone: **(required)**

Date of Birth: **(required)**

Email Address: **(required)**

How did you hear about us? **(required)**

Choose all that apply

☐ Friend ☐ Website ☐ Pastor Referral ☐ Another Counselor ☐ Other

Emergency Contact: **(required)**

Current Living Arrangements **(required)**

Choose all that apply

☐ Parents ☐ Children ☐ Spouse ☐ Roommate ☐ Aunts and Uncles ☐ Nieces and Nephews ☐ Friends ☐ Siblings ☐ Other

Highest Education Level **(required)**

Choose only one

☐ High School or GED ☐ Some College ☐ Completed College with Associates or Bachelor
☐ Master Degree ☐ Doctorate ☐ Currently in High School or Middle School

Current Work/Employement **(required)**

Reason For Visit: **(required)**

Allergies: **(required)**

Medications currently taking **(required)**

Do you have any experience with counseling/therapy or life coaching? **(required)**

☐ Yes ☐ No

If you have previous counseling experience please provide information concerning how long ago, type of treatment, issues, etc.

Do you have problems, according to you or someone close to you, with any of the following (check all that apply): **(required)**

Choose all that apply

☐ Spending too much time on the internet ☐ Pornography ☐ Outbursts of anger ☐ Thoughts of wanting to commit suicide ☐ Intentionally harming self to feel better ☐ anxiety ☐ relationship issues ☐ Thoughts of depression or sadness ☐ Regret over past mistakes ☐ Spending too much time playing games (either online or via console like playstation ☐ Gambling ☐ Not being able to stop a behavior after repeated attempts ☐ Hurt others because of not being able to stop the problem bringing you to counseling ☐ Struggle with relationship to food (either eating too much or not enough) ☐ Not feeling positive about self ☐ Alcohol ☐ Grief/Loss ☐ Drugs ☐ Tobacco ☐ Other

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Reason for seeking counseling: **(required)**

Do you have any questions concerning counseling? **(required)**

☐ Yes ☐ No

Questions concerning counseling

What method of counseling would you prefer? (Check all that apply) **(required)**

Choose all that apply

☐ Face to face ☐ Online Video ☐ Online Chat ☐ Telephone