FLOWER MOUND COUNSELING
GROUP/ CAMP INTAKE FORM

Client Name: _____
Last *First* *Middle*

Date of Birth:_____ Current Grade:_____

Parent/Guardian Name:_____

_____
Address
_____
City *State* *Zip Code*
Phone numbers: _____ _____ _____
Home *Cell* *Work*
May I leave a message for you at home? Y / N
May I leave a message for you at work? Y/ N
May I leave a message for you on your cell? Y/ N
May I contact you via email? Y/ N
Please list the email address that you wish to be contacted at (we do not release email addresses):
_____

Household Members:

Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____
Name:_____ Age:____ Relationship:_____ Resides:_____

Briefly describe your reason for seeking counseling: _____
_____
_____
What goals do you hope to achieve by attending counseling?_____
_____
_____

List any major health problem for which client currently receives treatment:
_____

Medication:	Dosage:	Treatment of Symptoms:	Length of Use of Medication:
_____	_____	_____	_____
_____	_____	_____	_____

Current hobbies/ personal interests:_____

Current religious/spiritual beliefs:_____
_____

Current grades in School:_____
_____

Has client ever been bullied at school?_____

How many times per week does your family sit down for meals together?
_____

Has any family member ever struggled with any of the following symptoms/behaviors? And if so, please name the family member and date it began/ended.

Anorexia/Bulimia:
Drugs/Alcohol :
Fighting :
Cutting/Self-Harm:
Suicidal thoughts/attempts:
Homicidal thoughts:
Running away:
Truancy:
Depression:
Anxiety:
Gang/criminal activity:
CPS Involvement:
Domestic Violence:
Physical/Sexual Abuse:

Is there anything else your therapist may find helpful in knowing in regards to the treatment you are seeking for your family? _____

Have you ever previously attended therapy or received counseling services of any kind? Yes____ No_____ If yes please list the type of therapy you received_____

Did you find treatment helpful?_____
Previous therapist: _____

Reason treatment terminated?_____

Previous Psychiatric Hospitalizations?_____

Treatment and Diagnosis Rendered?_____

Do you anticipate being involved in a lawsuit in the near future? Y/ N
If yes, please explain_____
_____
Have you ever been a party to a lawsuit? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:
_____
_____
Have you ever filed a complaint with a licensing or regulatory authority? Y/ N
If yes, please provide a description of the suite, the date, and the outcome:
_____
_____

How did you hear about us?_____
_____
Customer Satisfaction Survey: Upon discharge we will ask you to complete a client satisfaction survey. The survey is anonomous and confidential and is used so that we can improve the quality of our services. Please provide us with your email address. We do not release email addresses to third parties.
I would like the survey sent to my email address at:
_____
Would you like to receive our e-newsletter? Yes/ No
(We do not release email addresses to third parties)