Restore Counseling, LLC

INTAKE ASSESSMENT

Section 1: Demographic Information

Patient Demographic Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Have you been in therapy in the past? If so, what worked well for you?

1. What is your main goal in seeking support at this time?

2. Do you have any of the following concerns? If so, please circle or mark.
    - Substance abuse/over-use
    - Domestic violence
    - Medical issues
    - Parenting challenges
    - Sexual difficulties
    - Self-esteem
    - Suicidal thinking or actions
    - Self-harming behavior
    - Anxiety or depressive symptoms
    - Anger outbursts
    - Relationship difficulties
    - Work challenges

3. What is most important to you in feeling supported in counseling?