MILITARY VETERAN

INTAKE FORM

GENERAL INFORMATION

Name:_____ Date of Birth: _____ Age:_____

Address:_____City:_____Zip:_____

Telephone:_____ Last 4 of Social Security number:_____

Authorization # (if already obtained for treatment)_____

Emergency contact name, phone number and relationship to the client:

_____

Branch of military:_____ Rank:_____

What job did you have in the military?_____

What dates did you serve in the military?_____

Were you deployed? _____

Did you see combat___yes___no enemy fire___yes___no casualties___yes___no

Do you have close family members that served in the military?_____

_____

Relationship status:___married___single___separated___divorced

Name and age of children:_____

Were you raised by: [ ] Both parents? [ ] Single parent? [ ] Relative? [ ] Adopted? [ ] Other?

How many siblings do you have and where do you fall in the birth order:

_____

_____

In your family is there a history of: [ ] Alcoholism [ ] Drug Addiction [ ] Mental Illness [ ] Prolonged physical illness

Do you struggle with addiction currently or in the past (alcohol, drugs, porn, video games, gambling):_____

MENTAL/PHYSICAL HEALTH HISTORY

Are you currently doing individual counseling? ___yes ___no

Have you done counseling in the past?

If yes, please indicate the year and duration_____

Have you received a formal diagnosis? If yes, please indicate diagnosis and date of the diagnosis_____

Is your diagnosis/condition service connected?_____

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders or other psychiatric disorders:

_____

_____

Have you ever attempted suicide or struggled with suicidal thinking?_____

_____

Do you have any significant medical conditions?_____

_____

_____

Please list all of the medications and supplement that you are currently taking:_____

_____

_____

LIFESTYLE OVERVIEW

How much sleep do you get: [ ] 3-5 hrs. per night [ ] 5-7 hrs. [ ] 7-9 [ ] 9-12 hrs.

How many times a week do you exercise and what type of exercise do you prefer:

_____

_____

Describe your eating habits (do you eat three meals a day, vegetables, fruits, meat, snacks, late night eating...):_____

_____

What junk food do you love to eat (soda, chocolate, chips...) and how often do you eat these foods: _____
_____

If you drink alcohol, what are your drinking habits: [ ] rarely drink [ ] 1-3 times per week [ ] 3-5 times per week [ ] everyday [ ] don't intend to drink as much as I do sometimes [ ] black out when drinking [ ] drink to get drunk

PERSONAL INSIGHT

What do you feel are the obstacles that limit you from living the best life you can?_____
_____
_____
_____

Name 4 Goals you would like to work towards in therapy:

1._____

2._____

3._____

4._____

What are 4 personal strength that you have:

1._____
2._____

3._____

4._____