Koppa Counseling, PLLC
Rachel Koppa, Ph.D., LPC-S, LMFT
12720 Hillcrest Rd Suite 120
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214-224-0970
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Intake Form

Generalized Information:

Name:			
Age:	**DOB:**	**Today's Date:**	
Address:			
Telephone number(s)	**Home:**	**Work:**	**Cell:**
Can I leave a message at this number?	YES/ NO	YES/ NO	YES/ NO
Preferred way to be contacted (circle choice):	Home	Work	Cell
May you be contacted by Email? YES / NO		**Email:**	

Please, include spouse/ partner, or child's information if seeking couples/family therapy:

Name			
	Age	**DOB:**	
Address:			
Telephone number(s)	**Home**	**Work**	**Cell**
Can I leave a message at this number?	YES/ NO	YES/ NO	YES/ NO
Preferred way to be contacted (circle choice):	Home	Work	Cell
May you be contacted by Email? Yes / NO		**Email:**	

Please include information if treatment is for minor child:

Parent/Legal guardian name:		
Who does child live with?		
Grade:	**School**	**Teacher**

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In case of emergency, whom may I contact on your behalf?	**Name:**
Phone number:	**Relationship:**

If you have been previously married, please fill out the following section:

	Date began:	**Date ended:**	**Ex spouse name**	**Children**
1st Marriage				YES / NO
2nd Marriage				YES / NO
3rd Marriage				YES/ NO

Family of origin: List: parents, siblings, stepfamily, and any other significant family members. If seeking couples/family therapy please indicate *both* partners family of origin information. If person is deceased put an "X" in the age box and indicate date of death. **Please, list your children in the next section.**

Name	**Age**	**Relationship**	**City, State**

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Children: (list all children, including biological, adopted, foster, and step children)

Name	**Age**	**Relationship**	**City, State**	**Lives at home?**
				YES/ NO
				YES/ NO
				YES/ NO
				YES/ NO
				YES/ NO
				YES/ NO

Marital/ Partner/ Relationship Status (circle all that apply):			
Single	Married	Divorced	Separated
Widowed	Remarried	Long-term relationship	Cohabitating
Current partner's name	**Partner's occupation:**	**Length of relationship:**	
How satisfied are you with your current relationship (on a scale from 1-10)? (very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)			

What is your occupation?	**Employer:**
Do you enjoy your occupation? YES / NO	**Average hour worked per/week**

Highest level of education:	High school	Some college	College degree	Graduate School	Other
If you received a college/graduate degree, what was your degree in?					
If you are currently in school, what are you studying?					

How would you describe your spiritual or religious beliefs?

Have you ever received or given abuse? YES/ NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other

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Do you have a primary care physician? YES / NO	**Physician name:**
Are you under the care of a psychiatrist? YES/ NO	**Psychiatrist name:**
If minor does child have a pediatrician? YES/ NO	**Pediatrician name:**

Are under the care of specialist? YES/ NO					
If yes, please circle specialist(s) which provide you care:					
Cardiologist	Dermatologist	Endocrinologist	Gynecologist	Infertility Specialist	Nephrologist
Neurologist	Nutritionist	Occupational therapist	Oncologist/ Hematologist	Orthopedic Specialist	Pain Specialist
Physical Therapist	Psychiatrist	Rheumatologist	Sleep Specialist	Urologist	Other:

Please list any chronic illness, disabilities, medical conditions that you have been diagnosed with:

Illness/Disability	Dates

List all medications you are currently taking, including those you seldom use or take only as needed

Medication	**Dosage**	**Treating**
Are you taking the medications according to your doctor's recommendation? YES/ NO	**If no, briefly explain:**	

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Average number of hours you sleep a night? **_____hrs**	**How long does it take you to fall asleep?** _____min. _____hrs.
Do you wake up in the night? YES / NO	**If yes, how often** _____ times per night
How would you rate your overall sleep at the present time? **(poor)** 1 2 3 4 5 6 7 8 9 10 **(excellent)**	

Do you exercise on a regular basis? YES / NO	**If yes, how often**
If yes, please describe activity briefly:	

How would you rank your overall diet on a scale form 1-10? **(poor)** 1 2 3 4 5 6 7 8 9 10 **(excellent)**

Do you drink alcoholic beverages? YES/ NO	**If yes how many alcoholic beverages do you drink** _____ weekly _____ daily
Do you think you have a drinking problem? YES/ NO	**Does anyone else think you have a drinking problem?** YES/ NO

Do you smoke? YES/ NO	**If yes how many cigarettes/packs a day does you smoke?** _____cig. _____ packs a day
If yes when did you start smoking? _____ age	**Have you ever tried to quit?** YES/ NO /NA

Have you in the past or currently used abused, experimented with illegal drugs? YES/ NO	**If yes, briefly describe:**

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Have you ever attempted/ seriously contemplated suicide? YES/ NO
If yes, describe briefly and indicate dates:
Have you ever had a psychiatric hospitalization? YES/ NO
If yes describe briefly and indicate dates

Therapy Experiences and Expectations:

Are you *currently* seeing another therapist? YES / NO			
If yes, whom are you seeing?			
Have you ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	**Location**	**Dates**	**Reason**

What goals do you wish to accomplish during the therapy process?

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Is there anything else you would think would be important for me to know about you or your family

Who referred you?	**May I contact him or her to thank them:** YES/ NO