Bethany Comeau, MA, LPC
Bethany Comeau Counseling & Consulting, LLC
205 South Lee Street, Americus, GA 31709
(229) 380-0560

Intake Forms

Please provide the following information and answer the questions below.

Note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children and their ages:

_____

_____

Full Mailing Address Including City, State, and Zip Code

_____

_____

Home Phone: _____May I leave a message? □Yes □No

Cell: _____May I leave a message? □Yes □No

How did you find out about my services?

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list:
_____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your child's current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____?

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, when did you begin experiencing this?

_____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe

_____

8. Do you drink alcohol more than twice a week? □ No □ Yes

9. How often do you or your child/teen engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a relationship with a significant other? □ No □ Yes

If yes, for how long?

_____

On a scale of 1-10, how would you rate your relationship? (1 being poor, 10 being very good)

_____

11. What significant life changes or stressful events have you experienced recently?

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes,
please indicate the family member's relationship to you in the space provided (father,
grandmother, uncle, etc.).

Please Circle & List Family Member

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Depression yes/no_____

Domestic Violence yes/no_____

Eating Disorders yes/no_____

Obsessive Compulsive Behavior yes/no_____

Schizophrenia yes/no_____

Suicide Attempts
yes/no_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes
If yes, name and address of your employer:

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

3. What would you like to accomplish out of your time in therapy?

_____