BOWLING COUNSELING CENTER INTAKE FORM

Note: This information is confidential

Demographic Information:

Name:

Date:

Date of Birth:

Age:

Relationship Status:

SSAN:

# of Dependents:

Gender M / F

Home/Cell Phone:

Work Phone:

Mailing Address:

Is it ok to mail things to this address?

Current Employer:

Position Title:

Emergency Contact Name:

Emergency Contact Phone #:

How were you referred?

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	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens				
Diarrhea				
Compulsive Exercise				
Use Laxatives				
Heart Problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early Morning Awakening				
Binge/Purge				
Poor appetite				
Eat “Junk Foods”				
Lack of Interest in Activities				
Constipation				
High Blood Pressure				
Allergies				

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Behavior -- circle any of the following behaviors that apply to you:

Overeat	Suicidal thoughts	Can't keep a job	Takes drugs	Compulsions
Insomnia	Vomiting	Smokes	Risky Behaviors	Odd Behavior
Withdrawal	Lack of Motivation	Drinks too much	Nervous tics	Eating Prob.
Works hard	Procrastination	Sleep Disturbance	Crying	Impulsive
Phobic	Outbursts of temper	Loss of Control	Aggressive	Concentration Problems

Are there any specific behaviors, actions, habits that you would like to change?

Feelings - circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious
Hopeless	Contented	Fearful	Hopeful	Excited	Sad
Panicky	Helpless	Optimistic	Energetic	Relaxed	Tense
Envious	Jealous	Others:			

Physical- circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness
Tics	Dry mouth	Palpitations	Fatigue
Burning or itchy skin	Muscle spasms	Twitches	Chest pains
Tension	Back Pain	Rapid heart beat	Sexual disturbances
Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hears things	Excessive sweating	Tingling
Watery eyes	Visual disturbances	Numbness	Hearing problems

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

Please list medicines you are currently taking, or have taken in the past 6 months.

Do you get regular exercise? If so, what type and how often?