The Seed Planter Coaching & Counseling, PLLC
Nanette Floyd Patterson, MA, LPC

INTAKE FORM

Name	**Date**
Date of Birth	**Relationship Status**
Age	**Home Number**
# of Dependents	**Gender (Male/Female)**
Guardian's Name	**Telephone**
Mobile Phone	**Is it ok to leave a message at this number? (Yes/No)**
Work Phone	**Is it ok to leave a message at this number? (Yes/No)**
Email	**Is it ok to email you? (Yes/No)**
Mailing Address (include apartment/suite #)	**City, State, Zip**
Skye Name (if necessary)	
Current Employer	**Position Title**

Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):

Primary Insurance	**MID #**
MIDD#	**Subscriber Name**
Emergency Contact Name	**Emergency Contact Relationship**
Emergency Contact Phone	**Emergency Contact Email Address**

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How were you referred? **If online, which website?**

Current Concerns (feel free to attach additional sheets):

What concern brings you in?

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

Name 3 goals you would like to accomplish during counseling?

1.

2.

3.

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What kind of obstacles could get in the way?

What are your strengths?

What are your weaknesses?

What would you say are your needs right now?

Have you been in counseling before or received any prior professional assistance for your concerns? If so, please give dates of treatments, diagnosis, name and contact information of counselor and results:

Behavior – check any of the following behaviors that apply to you:

☐ Overeat	☐ Suicidal attempts	☐ Can't keep a job	☐ Take drugs	☐ Compulsions
☐ Insomnia	☐ Vomiting	☐ Smoke	☐ Take too many risks	☐ Odd behavior
☐ Withdrawal	☐ Lack of motivation	☐ Drink too much	☐ Nervous tics	☐ Eating problems
☐ Work too hard	☐ Procrastination	☐ Sleep disturbance	☐ Crying	☐ Impulsive reactions
☐ Phobic avoidance	☐ Outbursts of temper	☐ Loss of control	☐ Aggressive behavior	☐ Memory problems
☐ Destructive	☐ Emotionally abusive	☐ Fidgety	☐ Hyper	☐ Hear things not there
☐ Sadness	☐ Fatigue	☐ Excessive Weight Gain/Loss	☐ Low Self-esteem	☐ See things not there

☐ Thoughts of Killing Self or Others ☐ Concentration Difficulties ☐ Other: _____

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

Feelings – check any of the following feelings that apply to you:

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

Physical – check 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	☐ Hear things	☐ Excessive sweating	☐ Tingling	☐ Watery eyes
☐ Visual disturbances	☐ Numbness	☐ Flushes	☐ Hearing problems	
☐ Don't like being touched				

Premarital/Marital: check any of the following symptoms that apply to you:

☐ Excessive Arguments	☐ Infidelity	☐ Emotional Abuse	☐ Physical Abuse
☐ Financial	☐ Excessive Anger/Outburst	☐ Possessiveness	☐ Jealousy
☐ Lack of Sexual Drive	☐ Lack of Communication	☐ Family Involvement	☐ Excessive Stress
☐ Conflict with In-laws	☐ Children related conflict	☐ Differences in parenting	☐ Lack of support
☐ Forgiveness	☐ Bitterness	☐ Fear	
☐ Other (please share)			

Biological Factors:

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

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

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Do you get regular exercise? ☐ Yes ☐ No If so, what type and how often?

When was the last time you had a complete physical? _____

Who is your Primary Care Physician (name **and** telephone Number)?

_____ _____
Name **Phone Number**

Traumas/Domestic Violence/Rape/Molestation/Abuse/Neglect/CPS Involvement:

Traumas	☐ Yes ☐ No	Age?: _____	
Domestic Violence	☐ Yes ☐ No	Currently?: ☐ Yes	☐ No
Rape/Molestation	☐ Yes ☐ No	Age?: _____	
Abuse	☐ Yes ☐ No	Age?: _____	
Neglect/CPS Involvement	☐ Yes ☐ No	Age?: _____	

Psychological Factors:

Have you ever thought about suicide? ☐ Yes ☐ No

If "Yes", when? _____

Have you ever been admitted to a psychiatric hospital? ☐ Yes ☐ No If yes,

_____ _____
What year **Name of Hospital**

Career/Job:

☐ Excessive Stress ☐ Workplace Conflict ☐ Harassment

☐ Desire to change jobs ☐ Desire to pursue passion ☐ Desire to assess skills, abilities, and talents

☐ Personal Growth & Development ☐ Feelings of Anger ☐ Demoted

☐ Conflict with supervisor ☐ Conflict with coworker ☐ Recently terminated

☐ Desire to pursue calling ☐ Desire to start a business

☐ Other: _____

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SUBSTANCE USE: Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana	☐	☐	☐	☐	Heart problems	☐	☐	☐	☐
Tranquilizers	☐	☐	☐	☐	Nausea	☐	☐	☐	☐
Sedatives	☐	☐	☐	☐	Vomiting	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	Insomnia	☐	☐	☐	☐
Cocaine	☐	☐	☐	☐	Headaches	☐	☐	☐	☐
Painkillers	☐	☐	☐	☐	Backaches	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	Early morning awakening	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	Fitful sleep	☐	☐	☐	☐
Cigarettes	☐	☐	☐	☐	Binge / Purge	☐	☐	☐	☐
Narcotics	☐	☐	☐	☐	Poor appetite	☐	☐	☐	☐
Stimulants	☐	☐	☐	☐	Eat “junk foods”	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐	Lack of interest in activities	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	Constipation	☐	☐	☐	☐
Compulsive Exercise	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Use Laxatives	☐	☐	☐	☐	Allergies	☐	☐	☐	☐

Preferences:

☐ Prayer ☐ Fasting ☐ Bible Scripture ☐ Meditation ☐ No Thank You

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Mode of Counseling: (Medicaid& BCBS can only check face to face)**:**

☐ Face to Face ☐ Skype ☐ Telephone ☐ Email

Service Requested:

☐ Counseling ☐ E-Counseling ☐ Coaching ☐ Coaching/Counseling ☐ Group Coaching

Payment Option:

☐ Cash ☐ Certified Check ☐ Credit Card/PayPal ☐ Insurance

If you have insurance, indicate carrier _____

**For Medicaid, NC Health Choice & BCBS, all counseling begins with a comprehensive assessment. A mental health diagnosis is needed in order for insurance reimbursement.

How did you hear about us? _____