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CLIENT INTAKE FORM

Legal Name: ____ ❑ Male ❑ Female ❑ Other

Name client prefers: ______________________________ Date of Birth: ____________________ Age: _______

Mailing Address: _______________________________________ City: _______________ Zip: ____________

Home Phone: _________________________ ❑ Ok to leave message ❑ Ok to text

Cell Phone: ___________________________ ❑ Ok to leave message ❑ Ok to text

Occupation: __________________________________ Employer: ___________________________________

Relationship status: ❑ Single ❑ Married ❑ Domestic Partnership ❑ Separated ❑ Divorced ❑ Widowed ❑ Other

How long with current partner(s)? ____________ Name(s): ____________________ Living together? ❑ Yes ❑ No

Children (names and ages): ____

In case of emergency contact: ____ Phone: ____________________

Relationship to client: _________________________ Referred by_____________________________________

Insurance Co: __________________________ Copay: ________ Deductible: ________ Deduct Met? ❑ Yes ❑ No

Your answers to the questions below may provide additional information that will be beneficial to our counseling sessions. Please answer the questions below as completely as is comfortable for you. All answers will be kept confidential.

About counseling...

Briefly describe the problem that brings you to counseling: ____

____

____

What have you done to try and resolve this problem? ____

____

____

After counseling, what do you hope will be different regarding this problem? ______________________________

____

____

What previous experience do you have with counseling? ____

____

____

Please mark any of the following that you are currently experiencing:

- ❏ Distractibility
- ❏ Change in appetite
- ❏ Suspicion/paranoia
- ❏ Hyperactivity
- ❏ Lack of motivation
- ❏ Racing thoughts
- ❏ Impulsivity
- ❏ Withdrawal from people
- ❏ Sexual problems
- ❏ Anxiety/worry
- ❏ Loneliness
- ❏ Increasing alcohol/drug use
- ❏ Poor memory/confusion
- ❏ Panic attacks
- ❏ Sleep problems
- ❏ Fear away from home
- ❏ Nightmares
- ❏ Homicidal thoughts
- ❏ Sadness/depression
- ❏ Social discomfort
- ❏ Eating problems
- ❏ Loss of pleasure/interest
- ❏ Obsessive thoughts
- ❏ Gambling problems
- ❏ Hopelessness
- ❏ Compulsive Behavior
- ❏ Computer addiction
- ❏ Aggression/fights
- ❏ Problems with pornography
- ❏ Relationship problems
- ❏ Self-harm behaviors
- ❏ Frequent arguments
- ❏ Parenting problems
- ❏ Irritability/anger
- ❏ Low self worth
- ❏ Flashbacks
- ❏ Work/school problems
- ❏ Guilt/shame
- ❏ Hearing voices
- ❏ Visual hallucinations
- ❏ Other:________________________
  ____

Current substance use:

Type of Substance:	Amount of Use:	Frequency of Use:	Date of last use:

Past substance use:

Type of Substance:	Amount of Use:	Frequency of Use:	Date of last use:

Are you currently experiencing suicidal thoughts? ❏ Yes ❏ No If yes, please describe: ____________________________

____

Have you experienced suicidal thoughts in the past? ❏ Yes ❏ No If yes, please explain: ___________________________

____

Have you ever attempted suicide? ❏ Yes ❏ No If yes, when ____

If yes, please describe the attempt(s): ____

____

Are you or anyone in your household currently experiencing abuse or violence of any kind? ❑ Yes ❑ No

If yes, please explain: ____

____

About relationships…

How would you describe your current intimate relationship(s) (if any): ________________________________

____

____

Tell me about your network of social support (friends, family, coworkers, neighbors, religious/spiritual, self-help/support groups, etc.) ____

____

Do you feel you have an adequate support system? ❑ Yes ❑ No

About medical history…

How would you describe your physical health? ____

____

Are you currently being treated for any medical conditions? ❑ Yes ❑ No Please explain. ____________________

____

Are you currently taking any medication for mental health or medical condition? ❑ Yes ❑ No

Medication: ___________________________ Dosage: ________ per/______

Medication: ___________________________ Dosage: ________ per/______

Medication: ___________________________ Dosage: ________ per/______ (if more please attach)

Prescriber: ___________________________________ Phone: _______________________ Fax: _______________________

Other…

Is there anything else you feel is important for me to know (past trauma, grief or loss, etc) _________________________

____

____

Thank you for taking the time to answer these questions.