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Client Intake

The information provided in the pages that follow is used to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be addressed in your counseling services. A separate form is needed for each participant. Please answer as thoroughly as you can.

BASIC INFORMATION

Date _____

Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip)

Email: _____ May I contact you via email? YES NO

Date of Birth: ____/____/____ Gender: Male Female Social Security #: ____-____-____

Cell phone (____) _____ May I leave a message? YES NO

May I send text messages regarding scheduling? YES NO

Home phone (____) _____ May I leave a message? YES NO

Work phone (____) _____ May I contact you at work? YES NO

Who may we contact in the event of an emergency?

Name: _____ Relationship: _____

Phone number: (____) _____

Other Family Members Living With Me:

Name Age Name Age

Name Age Name Age

Name Age Name Age

Referred by (if any): _____

Do we have your permission to thank the person who referred you? YES NO

BACKGROUND INFORMATION:

Occupation(s): _____

Employer: _____

How would you rate your level of satisfaction at your current employment? (Place an X on line below)

DISSATISFIED _____ HIGHLY SATISFIED

Currently, I am:

____ Single

____ Coupled, but not married

____ Married (wedding date: _____)

____ Divorced (date of divorce: _____)

____ Widowed (date of spouse's death: _____)

Have you ever been married before? YES NO If yes, please explain your relationship background:

Are you currently involved or do you expect to be involved in any court related matters? YES NO

If yes, please describe:

MEDICAL/HEALTH HISTORY AND INFORMATION:

Do you regularly have physical wellness check-ups? YES NO

Please indicate any medical conditions that we should be aware of:

Please list the medications you are currently taking:

How many times per week do you generally exercise?

What types of exercise do you participate in?

ALCOHOL/DRUG HISTORY:

Do you drink alcohol? YES NO

Have you ever been arrested for driving under the influence (DUI)? YES NO

Do you use recreational drugs? YES NO If yes, what drugs do you use and how often?

SPIRITUAL INFORMATION:

Do you consider yourself to be religious or spiritual? YES NO

If yes, please describe:

COUNSELING/MENTAL HEALTH HISTORY:

Are you currently seeing a counselor, therapist, psychologist, or psychiatrist? YES NO If yes, who?

Have you ever had counseling before? YES NO If yes, when and briefly describe the circumstances that led you to seek counseling services:

Was it helpful? YES NO If not, why not? _____
Have you ever had medication prescribed for psychiatric or emotional difficulties? YES NO
If so, please list:

Have you ever been hospitalized for mental or nervous problems? YES NO If yes, when and where:

Have you ever attempted suicide? YES NO If yes, how and when, and indicate the type of treatment you received following the attempt:

Are you suicidal now? YES NO

Have you ever been physically, sexually, emotionally abused? YES NO If yes, briefly describe each event: _____

Are you experiencing any issues related to sexuality (i.e. compulsive pornography use, desire, performance, other)? YES NO If yes, please explain:

Have you had any significant events – either positive or negative – occur recently or within a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, etc?

Circle the following terms that apply to you.

- | | | | |
|-----------------------------|-------------------|-----------------------|-----------------------|
| Nervousness | Health Problems | Marital Problems | Drug Usage |
| Shyness | Stomach Problems | Divorce | Alcohol Usage |
| Anger | Bowel Problems | Separation | Financial Problems |
| Loneliness | Depression | Affair | Problems w/ Friends |
| Frustration | Headaches | Problems w/ ex-spouse | Can't Have Fun |
| Temper | Memory Loss | Stress | Tiredness |
| Self-Control | Sleeping Problems | Grief | Anxiety |
| Insecurity | Nightmares | Parenting Problems | Career Choices |
| Fears | No Ambition | Relationship Problems | Problems w/ Parents |
| Panic Attacks | Eating Problems | Legal Problems | Chronic Pain |
| Isolation | Suicidal Thoughts | Work Problems | School Problems |
| Can't Concentrate | Lack of Energy | Sexual Problems | Ritualistic Behaviors |
| Lying | Self-Mutilating | Short Attention Span | Bed Wetting |
| Crying Spells | Physical Abuse | Sexual Abuse | Emotional Abuse |
| Difficulty Making Decisions | | Other: _____ | |

Please describe briefly the concern or situation, which led you to seek services at this time:

How long has this been a concern? _____

Have you experienced this type of concern before? YES NO If yes, when? _____

Use the space below to provide clarification for anything circled above, if necessary:

What are your goals for treatment (what do you want to accomplish with counseling)?

Is there anything else you feel is important for your therapist to know?

Client Signature _____ Date _____