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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 to 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 _____