Client Intake

Date____________

Personal Information

Name ___________________________________ Age_______ Gender M F

Address___________________________City_______________State____Zip_______

Home phone_______________________Cell phone___________________________

Email address____

Date of birth_____________ Place of birth_________________ SS#_______________

Education (Highest grade completed)_____________Occupation_________________

Employer or school____

Hours worked per week_________ Years with employer___________

Are you satisfied with your job? Y N I don't know

Relational/Support History

Present marital status Single_______ Married ______ Remarried _____

Separated____ Divorced______ Widowed______

If you are in a romantic relationship how long have you been in this relationship?

____

Are you satisfied with your current romantic relationship? Y N I don't know

Do you feel supported by your partner/spouse? Y N I don't know

How would you rate the quality of your friendships?

Very Poor Unsatisfactory About Average Good Excellent

Besides family, how many people can you count on right now for friendship/emotional support?___________

Children's names and ages____

If married: Spouse's name_____________________Number of years married____ ____

Spouse's occupation_________________ Spouse's work phone__________

If child: Mother's name______________________________ Work phone__________

Father's name______________________________ Work phone__________

Parents' marital status_______________I live with _____________________

Physical Health

How is your physical health at present?

Poor Unsatisfactory Satisfactory Good Very Good

List any past health problems____

____

List any current medications (prescribed or non-prescribed)_________________________

____

Are you having any problems with your sleep habits? Y N

Are you having any difficulty with appetite or eating habits? Y N

Do you have any problems or worries about sexual functioning? Y N

If yes, please explain____

____

Are you suffering from symptoms of loss or grief? No Yes

If yes, please explain____

____

Physical health problems of close family members_________________________________

____

Mental Health

Have you ever been a victim of:

Emotional abuse as a child	Y	N
Physical abuse as a child	Y	N
Sexual molestation/abuse as a child	Y	N
Emotional abuse by a partner/spouse	Y	N
Physical abuse/assault by partner/spouse	Y	N
Sexual abuse/assault as an adult	Y	N

Other trauma (Specify)____

____

Previous Counseling Experience

Have you ever received psychological counseling before? Y N

If yes, when__________________________For how long?______________________

Why?____

Are you currently seeing a psychiatrist or have seen a psychiatrist in the past? Y N

If yes, where?__________________________When?_________________________

Duration__________________

What was the focus of the psychiatric treatment?____________________________

____

Do you have suicidal thoughts presently?

Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past?

Frequently Sometimes Rarely Never

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When?____

Have you ever attempted suicide? Y N

Date(s)____

Have you ever been hospitalized for psychological reasons? Y N

For what reason(s)?______________________________Date(s)___________________

Mental Health Family History:

____

____

____

Alcohol and other Drug use

How often do you drink alcohol?

Daily

3 or more times a week

1-2 times a week

Weekly

Monthly

Less than monthly

Never

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycontin, etc?

Daily

3 or more times per week

1-2 times per week

Weekly

Monthly

Never

Do you or does someone else think that you may need to cut down or stop using drugs?

Yes No Maybe

Problem Analysis

Briefly describe the problem you most wish help with right now:

____

____

____

How would you rate the intensity of the problem or concern that brought you in?

1 2 3	4 5 6	7 8 9 10
Not intense	Moderately intense	Extremely intense

How much has your current problem interfered with your life in general?

Not at all   A little   Somewhat   Moderately   To a great extent

If you could change anything about your life today, what would you change and why?

____

____

____

____

____

Symptoms

Please check any of the following symptoms you have been experiencing within the past two (2) weeks

________ Anxiety

________ Depression

________ Sadness

________ Anger

________ Irritability

________ Elevated mood

________ Headaches

________ Nausea/Vomiting

________ Stress

________ Dizziness

________ Shortness of breath

________ Suicidal thoughts

________ Feelings of hurting someone

________ Low self-esteem

________ Recent weight loss/gain

________ Insomnia

________ Change in appetite/eating habits

Referral Information

How did you hear about our office?____

May we add your name to our mailing list? Yes No

Email address____