Client Intake Form

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Please provide the following information for our records, prior to your first appointment. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: _____
(Last) (First) (Middle Initial)
If under age 18, name of parent/guardian:
_____
(Last) (First) (Middle Initial)
Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status: □ Single □ Divorced □ Separated □ Married □ Long-term Relationship □ Other _____

Live with: _____

Local Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No May we text you at this number? □ Yes □ No

E-mail: _____ May we contact you by email? □ Yes □ No *Please be aware that text and email may not be confidential.

Emergency contact name and phone number: _____

Referred by: _____ May we contact referral to thank them? Y or N

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:

_____

_____

How long has this been a problem? _____

Please check all the current behaviors and symptoms you consider problematic:

- □ Distractibility
- □ Hyperactivity
- □ Impulsivity
- □ Boredom
- □ Poor memory/confusion
- □ Seasonal mood changes
- □ Sadness/depression
- □ Loss of pleasure/interest
- □ Hopelessness
- □ Thoughts of death
- □ Self-harm behaviors
- □ Change in appetite
- □ Lack of motivation
- □ Withdrawal from people
- □ Anxiety/worry
- □ Panic attacks
- □ Fear away from home
- □ Social discomfort
- □ Obsessive/intrusive thoughts
- □ Compulsive behavior
- □ Aggression/fights
- □ Frequent arguments
- □ Suspicion/paranoia
- □ Racing thoughts
- □ Excessive energy
- □ Wide mood swings
- □ Sleep problems
- □ Nightmares
- □ Eating problems
- □ Gambling problems
- □ Computer/mobile addiction
- □ Problems with pornography
- □ Risky/illegal sexual behavior
- □ Parenting problems
- □ Crying spells
- □ Loneliness
- □ Low self-worth
- □ Guilt/shame
- □ Fatigue
- □ Irritability/anger
- □ Homicidal thoughts
- □ Flashbacks
- □ Hearing voices
- □ Visual hallucinations
- □ Sexual problems
- □ Relationship problems
- □ Work/school problems
- □ Alcohol/drug use
- □ Recurring, disturbing memories
- □ Rapid speech
- □ Phobias
- □ Excessive exercise
- □ Unexplained losses of time
- □ Unexplained memory lapses
- □ Suicide attempt
- □ Body image/body complaints
- □ Other:_____

Are your problems affecting any of the following?

□ Handling everyday tasks □ Self esteem □ Relationships □ Hygiene
□ Work/school □ Housing □ Legal matters □ Finances
□ Recreational activities □ Sexual activity □ Health

Have you noticed times when the problem isn't as bad? Explain: _____

Has anything like this happened before? _____ If yes, when, how often and how did you try to resolve this problem the last time?_____

How often has this problem occurred? _____

Who is involved or affected by this current problem/situation? _____

□ Yes □ No Have you had ever had thoughts, made statements, or attempted to hurt yourself (self-harm, suicide attempts, suicidial ideation)? If yes, please describe and note present or past (how long ago):
_____

□ Yes □ No Have you had ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:
_____

□ Yes □ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:
_____

□ Yes □ No Have you been physically hurt or threatened in the past (including sexual abuse/trauma)? If yes, please describe (to the extent you are comfortable): _____
_____

□ Yes □ No Have you experienced verbal or emotional abuse, witnessed an accident or crime, or experienced a natural disaster or chronic illness? If yes, please describe: _____
_____

□ Yes □ No Have you gambled in the past 6 months? If yes, please let us know the following:

□ Yes □ No Have you ever felt the need to bet more and more money?

□ Yes □ No Have you lied to people important to you about how much you gambled?

□ Yes □ No Are you engaging in other behaviors you have difficulty controlling or stopping, or that others have expressed concern about (e.g. gaming, pornography, obsessions, other sexual behaviors, etc.) If yes, please describe:
_____

CHILDHOOD HISTORY - please check items according to your own childhood (Birth – Age 19)

□ Someone pushed, grabbed, slapped, or threw something at child or child was hit so hard that she/he was injured or had marks
□ Household member swore at, insulted, humiliated, or put down child in a way that scared child or household member acted in a way that made child afraid that she/he might be physically hurt
□ Someone touched child's private parts or asked child to touch that person's private parts in a sexual way that was unwanted, against child's will, or made child feel uncomfortable
□ More than once, child went without food, clothing, or a place to live or had no one to protect her/him
□ Child often felt unsupported, unloved, and/or unprotected
□ Child's parents or guardians were separated or divorced
□ Child saw or heard household members hurt or threaten to hurt each other
□ Household member was depressed, mentally ill, or attempted suicide
□ Household member had a problem with drinking or using drugs
□ Household member served time in jail or prison
□ Child lived with a parent or guardian who died
□ Child was in foster care
□ Child was separated from primary caregiver through deportation or immigration
□ Child had a serious medical procedure or life-threatening illness
□ Child experienced harassment or bullying at school
□ Child experienced verbal or physical abuse or threats from a romantic partner (i.e., boyfriend or girlfriend)
□ Child often saw or heard violence in the neighborhood or school
□ Child was detained, arrested, or incarcerated
□ Child was often treated badly because of race, sexual orientation, place of birth, disability, or religion
□ Child (or sexual partner) became pregnant and experienced abortion or miscarriage
□ Child became a parent under the age of 20
□ Other: _____ □ None

HEALTH AND SOCIAL INFORMATION

Mental Health - Are you currently receiving psychiatric services, professional counseling or psychotherapy?

□ Yes □ No If yes, who is your current provider? _____

Have you had previous psychotherapy?□ No □ Yes - Previous therapist's name: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □ Yes □ No - If Yes, please list medication, frequency, and dose:

_____

Have you been previously prescribed psychiatric medication? □ Yes □ No - If Yes, please list medication, dose, and reason for prescription and for discontinuing: _____

Please list any previous mental health diagnoses, or indicate N/A if none: _____

_____

Physical Health - How is your physical health at present? □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

When was your last physical exam: _____ Name of physician: _____

Are you taking any *other* medications or supplements not listed above: □ No □ Yes, please list:

_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)

_____

Have you had any recent hospitalizations: □ No □ Yes, please describe: _____

Sleep – If you answered yes to problems with sleep, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

Activity Level – How many times per week do you exercise? _____ Approximately how long each time? _____ And to what intensity? _____

Eating – If you answered yes to problems with appetite or eating habits, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting □ Purging □ Laxatives □ Dieting □ Diuretics □ Intensive Exercise □ Other attempts to control body shape and size _____

Have you experienced weight change in the last 2 months? □ No □ Yes, please describe:

_____

Substance Use - Do you regularly use alcohol? □ No □ Yes In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

Have you experienced guilt or a desire to quit drinking, or have others indicated concern? □ No □ Yes, please describe:

_____

Have you been charged with a DUI/DWI or similar offense? If yes, indicate date(s) and result:

_____

How often do you engage in recreational drug use (prescription, non-prescription, legal, or illegal, including marijuana)?

□ Daily □ Weekly □ Monthly □ Rarely □ Never Type: _____ Last use: _____

Have you experienced a desire to quit using substance(s) and had difficulty quitting? _____

Do you use nicotine products? Daily □ Weekly □ Monthly □ Rarely □ Never □ More than 1 year ago

Relationships & Sexuality- Are you currently in a romantic relationship? □ No □ Yes, for how long? _____

Quality of current relationship (rate 1-10)? _____ How would you describe your sexual orientation? _____

Describe any problems in the area of relationships or sexual orientation: _____

Describe how you generally get along with other people (e.g. affectionate, follower, aggressive, shy, withdrawn, submissive, avoidant, leader, fight or argue, outgoing, etc.)

_____

Legal - Have you had any recent problems with the police, legal problems or are you party to a lawsuit? □ No □ Yes, please describe:

_____

RECENT EVENTS: Please check events that have occurred in the last 12 months (or longer ago and still trouble you)

□ Death of spouse
□ Divorce
□ Marital Separation
□ Jail Term
□ Death of close family member
□ Personal injury or illness
□ Marriage
□ Fired at work
□ Marital reconciliation
□ Retirement
□ Change in health of family member
□ Pregnancy
□ Birth or adoption of a child
□ Abortion
□ Miscarriage or stillbirth
□ Sex difficulties
□ Gain of a new family member
□ Business readjustment
□ Change in financial state
□ Death of a close friend
□ Change to a different line of work
□ Change in number of arguments with spouse
□ New Mortgage
□ Foreclosure of mortgage or loan
□ Change in responsibilities at work
□ Child leaving home
□ Trouble with in laws
□ Outstanding personal achievement
□ Spouse begins or stop work
□ Begin or end school
□ Change in living conditions
□ Revisions of personal habits
□ Trouble with boss
□ Change in work hours or conditions
□ Change in residence
□ Change in schools
□ Change in recreations
□ Change in church activities
□ Change in social activities
□ Change in sleeping habits
□ Change in number of family get-togethers
□ Change in eating habits
□ Vacation
□ Holiday stress
□ Minor violation of the law
□ Other _____

EDUCATION / OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes If yes: □ Full-time □ Part-time

If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors: _____

If no, do you desire to be employed? _____

Are you currently enrolled in school? □ No □ Yes If yes, describe: _____

Highest level of education completed: _____

CULTURAL/ETHNIC INFORMATION:

How do you describe your ethnicity? _____

Are you experiencing any problems due to cultural or ethnic issues? If yes, please describe:

_____

Other cultural information you believe is important for me to know:

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

How were you raised regarding spiritual things or religion? _____

Would you like to incorporate your faith into therapy sessions? □ No □ Yes

If yes, how would you like to incorporate your faith (e.g. prayer, scripture, etc.)

_____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g. art, books, crafts, working out, sports, hiking, church activities, volunteering, traveling, bowling, etc.): _____

_____

How often do you engage in these activities? _____

How often did you engage in them in the past? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check all that apply and list family member, e.g.,Sibling, Parent, Uncle, etc.):

Depression (non-Bi-Polar): □ No □ Yes _____

Bipolar Disorder: □ No □ Yes _____

Anxiety Disorders: □ No □ Yes _____

Panic Attacks: □ No □ Yes _____

Schizophrenia: □ No □ Yes _____

Alcohol/Substance Abuse: □ No □ Yes _____

Eating Disorders: □ No □ Yes _____

Learning Disabilities: □ No □ Yes _____

Suffered physical, sexual or emotional abuse: □ No □ Yes _____

Perpetrated physical, sexual, or emotional abuse: □ No □ Yes _____

Suicide Attempts: □ No □ Yes _____

Other: □ No □ Yes _____

GOALS:

What is your goal in coming to counseling / why are you seeking therapy now?

_____

What would you like to get out of this appointment time? _____

_____

What changes would you like to see happen? _____

_____

What are some things in your current situation you would like to keep or stay the same?

_____

How will you know (what will you be thinking and doing differently) that you won't need to come back anymore:

_____

OTHER INFORMATION:

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

Anything else you would like your counselor to know about you:

_____

_____ _____

Client or Legal Guardian **Printed Name** Date

_____. _____

Client or Legal Guardian **Signature** Date