CLIENT INTAKE INFORMATION

Dr. Oscar D. Ramirez - Therapist

Full Name First	Middle	Last	Date

Address	City	Zip

Social Security #	Date of Birth	Place of Birth	Age	Sex	Race / Ethnic Origin

Source of Referral: ❑ Self ❑ Family/Friend ❑ Hospital ❑ Pastor ❑ Other -

Present Marital status : ❑ Never Married ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced # _____ times ❑ Widowed

Home Phone	Work Phone	Employer	Employer's Address
( )	( )		

Other sources of income

Insurance Company	Policy Number

Emergency Contact	Relation	Phone
		( )

List family members (children, parents etc.) (Name)	Relation	Age	Alive	Deceased
1. (Father) _____				
2. (Mother) _____				
3. (Bro./Sis) _____				
4.(1/2 Bro/Sis) _____				
5. (Sons/Daughters) _____				
6. _____				
7. _____				

What problems are you experiencing that you feel you need help with?

1. _____
2. _____
3. _____

What prescription medication are you presently taking?	Dosages	Purpose
1. _____		
2. _____		
3. _____		

What non-prescription medication or over the counter drugs are you presently taking?	Dosages	Purpose
1. _____		
2. _____		
3. _____		

Client Name:

List any drug allergies:

List any food, chemical, or other allergies:

Are you experiencing any medical problems at the present time? ❑ No ❑ Yes, explain

How would you describe your present physical health?
Good ❑
Fair ❑
Poor ❑

Date of last check-up ❑ Unknown	Name of Physician	Phone

Do you have any communicable diseases? ❑ No ❑ Yes ❑ TB ❑ Hepatitis ❑ VD ❑ HIV/AIDS ❑ Unknown ❑ Other (explain)

Hospital or In-Patient Treatments (list most recent first) Name of In-Patient facility or Hospital	Treatment Dates	Reason for Treatment, Symptoms	Results of Treatment
1.			
2.			
3.			
4.			
5.			
6.			

Do you have any physical disabilities, limitations, or ailments ❑ No ❑ Yes (Explain)

COUNSELOR'S NOTES:

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Client Name:

EDUCATIONAL HISTORY

Do you have any problems or difficulty reading or writing?
❑ No ❑ Yes

If you speak more than one language, what do you consider your primary language?

Has anyone ever told you, or do you think that you may have a learning disability? ❑ No ❑ Yes Explain:

Were you hyperactive in school or at home? ❑ No ❑ Yes

Did you take medication for it? ❑ No ❑ Yes

Did you skip school a lot? ❑ No ❑ Yes
Did frequent illness causing you to miss school? ❑ No ❑ Yes, explain:

How many different schools did you attend? _____ Did you move around a lot during your school years? ❑ No ❑ Yes , explain:

Were you ever held back a grade in school? ❑ No ❑ Yes
If yes, what grade(s)

What is the highest grade that you completed?

Did you ever get in trouble in school? ❑ No ❑ Yes Were you ever suspended or expelled from school? ❑ No ❑ Yes

If yes, for what reason? _____

Were you ever involved in fights or other forms of violence in school? ❑ No ❑ Yes, explain:

Were you ever involved with, or a member of a gang?? ❑ No ❑ Yes Explain and give details of the type of activities that you did while in the gang.

Do you have a High School Diploma? ❑ No ❑ Yes
Do you have a GED? ❑ No ❑ Yes

Grade point average

Did you ever attend a trade or vocational school? ❑ No ❑ Yes

Did you ever attend College, or Adult Educational courses at college? ❑ No ❑ Yes

Are you interested in furthering your education - going back to school? ❑ No ❑ Yes Do you have any certificates of licenses? ❑ No ❑ Yes

What subject or area of interest?

Client Name:

VOCATIONAL & EMPLOYMENT HISTORY

What is your longest period of employment What company were you working for at the time?	Why did you leave?

What is your longest period of unemployment?
What did you do during this time?

What type of work do you do, or what is your job title?

Do you enjoy this type of work? ❑Yes ❑ No Explain

What type of work would you rather be doing?

Have you ever been in any branch of the military service? ❑ No ❑Yes ❑ Active Duty ❑ Reserve	What branch of the service	Dates of service From _____ to _____ From to	Type of discharge

What reasons, situations, or pressures ***caused you to enter*** the military

What was your Military Occupational Specialty (MOS / AFSC)?	Special Training

Did you ever receive an Article 15 or any other form of military discipline? ❑ No ❑ Yes
Explain:

Where were you stationed or deployed?

Were you ever deployed in a combat zone or in a combat support situation? ❑ No ❑ Yes
Explain

What was the most difficult or stressful event or circumstance that you experienced in the military?

Have you ever been diagnosed with Post Traumatic Stress Disorder? ❑ No ❑Yes,
Explain

Have you ever received any services from the Veterans Administration? ❑ No ❑ Yes

Client Name:

FINANCIAL

Do you receive a Disability or Pension ❑ No ❑Yes, Amount $

What is your primary source of income:

Are you ***presently*** receiving SSI or SSD? ❑ No ❑Yes, Amount per month $ Reason:
Have you ***ever*** received SSI or SSD ***in the past***? ❑ No ❑Yes, Amount per month $ Reason:

Are you in default, or behind in payments on any (student) loans ❑ No ❑Yes, Amount $ Owed to who?

Are you current on reporting your Federal Income Taxes? ❑Yes ❑ No Amount $ For what year(s)?

Do you ❑ own your own home or ❑ rent? ❑ live with parents or other relative

Do you own a car? ❑ No ❑Yes Year Make Model

How many credit cards do you own? What is your total credit card indebtedness?

Do you have a savings account? 401K? Other retirement plans

Do you believe you are a good budget planner? ❑ Good ❑ Average ❑ Bad ❑ None

Have you ever filed for bankruptcy? ❑ No ❑Yes Amount $

How would you describe your credit rating? ❑ Good ❑ Average ❑ Poor ❑ None

LEGAL HISTORY

Have you ever used any aliases, or are you known by any other name or nickname? ❑ No ❑ Yes Explain:

Do you have any charges pending in any court? ❑ No ❑ Yes
Charge

City, County State

Do you have any adult convictions? ❑ No ❑ Yes

Date	Charges or Type of Offense	Disposition	Time Served	Institution

Probation or Parole status

Notes:

Client Name:

ALCOHOL & DRUG USE HISTORY

Do you engage in any behavior that you wish you could stop (compulsive), or are you addicted to any *activity* or substance? ❑ No ❑ Yes
Explain

1. _____

2. _____

3. _____

4. _____

Have you ever used:

Marijuana	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Nicotine	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Liquor/Beer/Wine. . .	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Cocaine powder.	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Crack (rock)	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Heroin...	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
LSD (acid)	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Amphetamines	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Barbiturates...	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Mushrooms	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
PCP (Angel Dust)	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Ever used needles?	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Inhalants_____	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Other _____	Never ❑	Experimented ❑	Occasionally ❑	Frequently ❑	Drug of choice ❑
Other					

If you were to be limited to only one substance (including alcohol) what would it be?

Which drug do you feel causes you **the most overall harm?**
Why?

_____

_____

Has substance abuse been present in any other member of your family, or by anyone else in your home? ❑ No ❑ Yes, explain.

_____

_____

Do you find yourself struggling with ***activities*** such as:
Eating ❑ Dieting ❑ Sexual activities ❑ Pornography ❑ Relationships ❑ Exercise ❑ Gambling ❑ Work ❑
Computers / Internet ❑ Television ❑ Fiction/Romance novels ❑ Sports ❑ "dangerous" activities ❑
Collectibles _____ ❑ Pinball / Arcade games ❑ Chocolate/sweets ❑
Other (explain) :

Have you ever ***tried to stop*** (compulsive behavior, or ***reduce your consumption*** of substances) on your own? ❑ No ❑ Yes
What ways did you use to try to stop:

_____

_____

Do you engage in activities that other people may consider dangerous? ❑ No ❑ Yes Explain

_____

Are you receiving help from any other counselor, minister, therapist, psychologist, social worker or any other person? ❑ No ❑ Yes

Explain

Client Name:

Have you ever been involved in any other type of treatment or Recovery Program (AA, NA, 12 Step, Detox, Day Treatment, Etc) ❑ No ❑ Yes
Explain

What benefit do you feel you received from these programs?

Why do you feel that these other programs have not work for you?

Have you ever taken or had prescribed any form of psychotropic medication? ❑ No ❑ Yes For what symptoms? Explain.

SEXUAL HISTORY

Do you think you ever abused physically or sexually at any time when you were growing up ❑ No ❑ Yes, explain when and how:

How old were you when you first began to be active sexually?

Have you ever been involved sexually with anyone of the same sex?

Do you have any unusual sexual preferences?

Client Name:

SPIRITUAL HISTORY

Describe your previous church involvement or activities

How would you rate your present spiritual health?
Strong ❑
Average ❑
Weak ❑
Non-existent ❑

If you were to die today, **why** do you think God would or should let you into heaven?

Have you ever been involved in Cults (Jehovah's Witness, Mormon, Moonies, Etc.) ? ❑ No ❑ Yes, Explain.

Have you ever been involved in the occult (Santeria, tarot cards, Ouija boards, fortune telling, astrology, magic, etc.)? ? ❑ No ❑ Yes , Explain.

Have you ever had an "out of body" experience? ❑ No ❑ Yes , Explain.

Have you ever been involved in "thought projection" "mental telepathy" or hypnotism? ❑ No ❑ Yes, Explain.

Have you ever taken any blood oaths or vows ? ❑ No ❑ Yes, Explain.

Do you feel that God may have forgiven you for the things you have done, but you cannot forgive yourself? ❑ No ❑ Yes, explain:

Client Name:

PSYCHOLOGICAL HISTORY

Do you have reoccurring dreams or nightmares? ❑ No ❑ Yes Describe:

COMPLETE THE SENTENCE: Of all the things concerning myself, I am most self-conscious about .... (Explain)

What was the most traumatic time or event in your life? What made that event so traumatic?

Do you experience intrusive thoughts or flash backs? ❑ No ❑ Yes Describe.

Have you ever heard voices? ❑ No ❑ Yes, explain:

What objects, situations, circumstances, or people are the cause of your greatest fears? How seriously are you affected by these fears?

Have you ever been physically violent with another person or have you ever been accused of threatening someone else with violence? ❑ No ❑ Yes, explain:

CLIENT NAME:

Have you ever tried to harm yourself or attempted suicide? ❑ No ❑Yes, explain:

Has anyone in your family ever attempted suicide? ❑ No ❑Yes, explain:

Do you feel that you experience extreme mood swings (feeling ***very*** good and feeling ***very*** bad)? ❑ No ❑Yes

How would you describe your present mental health?

Good ❑ Fair ❑ Poor ❑

COUNSELOR NOTES: