CLIENT INTAKE FORM

Thank you for taking a few minutes to fill out this form. Please provide the following information for our records.
The information you provide is confidential.

Today's Date_____________________

Name ____Age ____________ Date of Birth ______/______/__________

Address ____
Street City State Zip

Phone (Home) _____________________________ Cell______________________________ Work______________________

Which number do you prefer we call and can we leave a message? ____

Email (please print clearly) ____

Emergency contact name, number & relationship, phone ____

Please describe your current living arrangement (Do you live with others?)

____

Highest Level of Education Completed _________________________ Occupation ____________________________________

Employer ____

Have you had previous counseling or psychotherapy before? □ No □ Yes If yes, Reason _______________________________

Dates Where

____

____

Medical History:

Primary Care Physician: Name ____ Last Date of Visit ______________________

Inpatient Last Date_______________________________________ Outpatient Last Date ___________________________

Are you on any medications? □ No □ Yes If so, what and why? ____

List any known Allergies____

Psychiatric History:

Have you had any past psychiatric hospitalizations? □ No □ Yes (describe and list dates)?

____

____

Inpatient Last Date____ Outpatient Last Date ___________________________

Have you taken any psychiatric medications in the past? □ No □ Yes List:

____

Are you currently taking any psychiatric medications? □ No □ Yes List:

____

Has a family member ever been hospitalized for mental or emotional illness? □ No □ Yes

If yes, please explain—dates, where, reason: ____

Substance abuse:

Have you ever been treated for SA or addiction history (food, gambling, alcohol, drugs, sex)? □ No □ Yes (please explain)

____

Have you taken any illegible drugs in the past 30 days? □ No □ Yes Please list_______________________________

Legal History:

Have you ever been arrested? □ No □ Yes Do you have any pending legal problems? _________________________

Presenting Problem: What is the reason you are seeking counseling? (frequency & duration of the problem)

____

____

____

What are your 2 most important goals for therapy?

1. ____

2. ____

Common problem/symptom checklist. Please select ALL that apply:

___Anxiety/Stress	___Sexual Abuse	___Physical Abuse	___Spiritual Issues
___Grief/loss	___ Avoidance	___Other addictions	___Post traumatic stress
___Sleep Disturbance	___Depressed Mood	___ Impaired Memory	___Alcohol/Drug Use
___Impulsiveness	___Paranoia	___Irritability	___Excessive Worry
___ Agitation	___ Impaired Concentration	___Poor Judgement	___Racing Thoughts
___ Panic Attacks	___Hopelessness	___Anger	___Communication issues
___Emotional Abuse	___Childhood Sexual Abuse	___Loneliness	___Self-esteem
___Personal Growth	___Mood swings	___Fatigue	___Risky Behavior

Family Information: Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Spouse's Name (if applicable) ________________________________ Age ________ Occupation __________________________

Number of children _____________ list ages and gender: ____

How many siblings do you have? ________ How would you describe your relationship? __________________________________

Trauma History: Do you/have you suffered domestic violence? □ No □ Yes
Do you have a history of sexual, physical, or emotional abuse? □ No □ Yes If so, which:
____

Suicide Risk Assessment:
Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had then in the past 24 hours? □ No □ Yes

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes If so, when was the last date of occurrence____

Where you every hospitalized for suicidal attempt? □ No □ Yes If so, when was the last date of occurrence and the name of the hospital ____

Current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? □ No □ Yes

If yes, describe ____

Who referred you to us? ____

Is there anything else that you would like us to know?

____

____

Verification of Insurance (*If Applicable*)

Primary Insurance Holder_______________________________________ DOB of Primary Holder____________________________________

Relationship to Client ( ) Self ( ) Parent/ Guardian SSN of Primary Holder____

Insurance Company____

ID#:____ Group#____

Signature____Date_____________________________________

Please bring this form with you to your first session, it will be reviewed with you during the session.