Survival 2 Victory
Counseling Services

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? _____□ No □ Yes

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 _____

Employer's Address _____

What is your religious background / involvement _____

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

_____

_____

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

_____

_____

Have you taken any psychiatric medications in the past? □ 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? _____

Medical Information: Doctor's name and phone _____

May we send your doctor a short note, letting him / her know you've come to see us? (we do not release details other than your name, for referral purposes) □ No □ Yes

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

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 that apply and indicate: 1 - mild, 2 - moderate, 3 - severe.

___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

Survival 2 Victory
Counseling Services

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.