



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 |



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 them 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.