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? _____

Email (please print clearly) _____

Emergency Contact Name and Relationship_____

Emergency Contact Telephone Number(s)_____

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

_____

Highest Level of Education Completed _____ Occupation _____

Employer _____

**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? _____

_____

**Medical History**:

Primary Care Physician: Name _____ Last Date of Visit _____

Inpatient Last Date_____ Outpatient Last Date _____

List any known Allergies_____

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

_____

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**Psychiatric History:**

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

_____

Inpatient Last Date_____ Outpatient Last Date _____

Have you taken any psychiatric medications in the past? □ No □ Yes If yes, please list:

_____

Are you currently taking any psychiatric medications? □ No □ Yes If yes, please list:

_____

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

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

**Suicide Risk Assessment**:

Have you had any suicidal thoughts recently? □ No □ Yes

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

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

Suicide Attempt: □ No □ Yes If yes, when was the last date of occurrence_____

Were you ever hospitalized for a suicidal attempt? □ No □ Yes If yes, when was the last date of occurrence and the name of the hospital _____

Have you had any homicidal thoughts: □ No □ Yes If yes, please explain_____

Do you have any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? □ No □ Yes

If yes, describe _____

**Trauma History**: Have you suffered from any of the following (please check all that apply) □ Sexual Abuse □ Physical Abuse □ Emotional Abuse □ Domestic Violence or □ Other, please explain_____

_____

**Substance Abuse/Addictions:**

Have you ever been treated for drugs, alcohol or any other abuse or addictions (food, gambling, 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? _____

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**Presenting Problem:** What is the reason you are seeking counseling? (how often & how long have you been dealing with this issue)

_____

_____

_____

What are your 2 most important goals for counseling? (i.e. *I want to stop feeling depressed, I want to learn to manage my anxiety, I want to talk about my trauma, I want to learn how to have healthy relationships*)

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 |

Have you had previous counseling before? □ No □ Yes If yes, Reason _____

Dates Where

_____

_____

**Were you referred to us?** □ No □ Yes **How did you hear about us?**_____

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

_____

**Verification of Insurance (*If Applicable*)**

Primary Policy Holder's Name_____ DOB for Primary Holder_____

Relationship to Client ☐ Self ☐Parent/Guardian ☐Spouse Insurance Company_____

Subscriber ID#:_____ Group#_____

Signature_____ Date_____

Please bring this form with you to your first session. For video sessions, please return this form before your first session.