Julian & associates
PSYCHOTHERAPY SERVICES

# Confidential Client Intake Form

*Please complete this form and bring it to your first session.*

Client name: _____ Date: ___/____/____

Name of parent/guardian (if client under 18): _____

Age: _____ Date of birth: ___/____/____ Gender identity: _____

Marital/legal status (circle): Single Partnered Married Separated Divorced Widowed

Others living in home (Please list name, relationship and age): _____

_____

Employer/School: _____ Occupation: _____

Referred by (if applicable):_____

**Client Contact Information----------**

Client street address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ OK to leave a message? YES NO

Home phone: _____ OK to leave a message? YES NO

Other phone: _____ OK to leave a message? YES NO

Email address: _____ OK to email? YES NO
(*Please note: Communication via email, cell phone or other medium is not considered confidential.)

**Emergency Contact Information----------**

Emergency contact name: _____ Relationship to client: _____

Primary phone: _____ Other phone: _____

Email: _____

Referred by (if any): _____

Briefly state reason(s) for seeking counseling: _____

_____

_____



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**Insurance Information (if applicable) ----------**

*Primary Insurance*

Policy holder name (F, M, L):_____

Policy holder address (if different from above):_____

City:_____ State:_____ Zip:_____ Policy holder Date of birth: ___/___/___

Primary Insurance Company: _____ Employer:_____

Policy ID#:_____ Group #:_____ Plan name:_____

*Secondary Insurance*

Policy holder name (F, M, L):_____

Policy holder address (if different from above):_____

City:_____ State:_____ Zip:_____ Policy holder Date of birth: ___/___/___

Primary Insurance Company: _____ Employer:_____

Policy ID#:_____ Group #:_____ Plan name:_____

**Client Health & Mental Health History----------**

Has client received previous mental health services (circle)? YES NO

Approximate number of visits, duration and year (psychotherapy or hospitalization): _____

_____

Outcome of previous mental health services: _____

Client currently taking or ever taken prescribed medications (circle)? YES NO

Medication name: _____ Dates: _____ to _____

Medication name: _____ Dates: _____ to _____

Medication name: _____ Dates: _____ to _____

Current psychiatrist (if applicable):_____

*Physical health*

Rate client's overall health (circle): Poor Fair Good Very good

Client current physical health problems or concerns: _____

_____

Current physican:_____

*(Health/Mental health history continued…)*

History of significant injury, chronic health conditions, chronic pain, etc: _____

Rate client's current sleeping habits (circle): Poor Fair Good Very good

Describe any concerns/recent change in sleep patterns: _____

_____

Rate client's current eating habits (circle): Poor Fair Good Very good

Describe any concerns/recent change in eating habits: _____

_____

Do you exercise regularly? YES NO How often?: _____

Type of exercise: _____

Are you currently experiencing any of the following symptoms (circle all that apply)?

| | | |
|---|---|---|
| Anxiety | Feelings of worthlessness | Mood swings |
| Anger | Grief or recent loss | Nightmares |
| Dependence on others | Guilt | Panic attacks |
| Depression | Headaches | Physical changes OR physical pains |
| Difficulty concentrating | Hearing voices/seeing things others don't see/hear | Problems at work |
| Difficulty dealing with demands | Impulsive behavior | Relationship problems |
| Feeling a sense of disconnection from self | Irritability | Sexual dysfunction/change in sexual functioning |
| Feeling a sense of disconnection from others | Loneliness | Sport performance or sport-related concerns |
| Feeling as though the world around you is not real | Low energy/fatigue | Stress |
| Feelings of inadequacy | Low motivation<br>Sadness | Unhealthy alcohol/drug use |

**Family History----------**

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex: father, grandmother, uncle, etc).

| | | | |
|---|---|---|---|
| Alcohol/Substance abuse | ___No | ____Yes | _____ |
| Anxiety | ___No | ____Yes | _____ |
| Depression | ___No | ____Yes | _____ |
| Disability | ___No | ____Yes | _____ |
| Divorce/separation | ___No | ____Yes | _____ |
| Domestic violence | ___No | ____Yes | _____ |
| Eating disorder | ___No | ____Yes | _____ |
| Obesity | ___No | ____Yes | _____ |
| Obsessive-compulsive disorder | ___No | ____Yes | _____ |
| Schizophrenia | ___No | ____Yes | _____ |
| Sexual abuse | ___No | ____Yes | _____ |
| Suicide | ___No | ____Yes | _____ |

Religious/spiritual background: _____

Cultural identification: _____

**Developmental History----------**

Achieve developmental tasks on target: _____

Highest level of education completed: _____

Learning concerns or problems: _____

Other: _____

**History of Trauma----------**

*Please place a check mark beside any traumatic event(s) you have experienced and include brief description and year of event.*

- O Childhood physical abuse _____
- O Childhood sexual abuse_____
- O Childhood emotional abuse_____
- O Physical attack (e.g., threatened, beaten up, etc)_____
- O Sexual violence (rape or attempted rape, sexually assaulted, stalked, etc)_____
- O Military combat or war zone experiences_____
- O Kidnapped or taken hostage_____
- O Serious accident, fire or explosion_____
- O Terrorist attack_____
- O Near drowning_____
- O Diagnosed with life threatening illness_____
- O Natural disaster (e.g., flood, tornado, etc)_____
- O Imprisonment or torture_____
- O Animal attack_____
- O Other (please specify): _____

**Substance Use History----------**

*Please place a check mark beside substances used and briefly describe frequency of use in the lines provided.*

- O Alcohol — How much/often: _____
- O Recreational drug(s) — How much/often: _____
- O Nicotine — How much/often: _____
- O Caffeine — How much/often: _____
- O Other (please specify): _____ How much/often: _____

**Social History----------**

Client currently involved in a romantic relationship? YES NO

Rate client's current relationship? Poor Fair Good Very good

Extracurricular activities: _____

Rate client's satisfaction with current friendships: Poor Fair Good Very good

Rate client's satisfaction with family relationships: Poor Fair Good Very good

Significant life changes or stressful events experienced recently: _____

_____

Client's perceived strengths: _____

Client's perceived areas of growth: _____

**Goals for Counseling----------**

What would you like to accomplish during your time in counseling? _____

_____

Reasons for seeking help: _____

_____

Other information or questions not mentioned: _____

_____