Ozmer Counseling, PLLC ~ Courtney Ozmer, MEd, LPC-S
550 S. Watters Road ∗ Suite 285 ∗ Allen, TX 75013 ∗ (972) 948-6392

ADULT CLIENT INTAKE

Please answer the following questions to the best of your ability. Your responses will help your counselor in establishing treatment goals and providing the best care possible. If there are questions you do not feel comfortable answering, please leave them blank.

Name of Client ____
Date of Birth _____________ Age ________Sex ________ Race _______ Religion ________________
Street Address ____ City ______________ Zip Code __________
May we contact you by mail at this address? Yes No
Email _______________________________May we contact you by email? Yes No
Home Phone_________________________May we contact you and leave messages at home? Yes No
Cell Phone __________________________May we contact you and leave messages on your cell? Yes No
Employer _______________________________________Work Phone _________________________
Job Title ____Education (years completed) _________________
May we contact you and leave messages at work? Yes No
Marital Status (Circle): Single / Engaged / Married / Separated / Divorced / Widowed / Cohabitating
Date of current marriage/separation ____________________________
Previously married? Yes No If yes, when? ___________________ How long? ______________
Spouse Information (if applicable)
Name of Spouse ____Number of years married ________
Date of Birth _____________ Age ________Sex ________ Race _______ Religion ________________
Child(ren)'s Name(s) ____________________________________Date of Birth_____________ Male Female
____________________________________Date of Birth _____________Male Female
____________________________________ Date of Birth _____________Male Female
____________________________________Date of Birth _____________Male Female
Who is currently living in your household? ____
____

<u>REASONS FOR SEEKING COUNSELING</u>
What brought you to counseling? Please list your concerns in order of importance ____________________
____
____
When did your present concerns begin to be a problem for you? ____________________________________
____
What do you hope to gain from counseling? ____
____
____

 Client Initials ______

Please indicate which of the following areas are currently problems for you. Check all that apply:

____ Feeling inferior to others
____ Under too much pressure and feeling stressed
____ Feeling down or unhappy/depressed mood
____ Work stressors
____ Loneliness
____ Suspicious feelings toward others
____ Angry feelings
____ Feeling “numb” or cut off from emotions
____ Concerns about physical health
____ Hallucinations
____ Hypersomnia (sleeping all the time)
____ Change in appetite (increase or decrease)
____ Loss of interest in usual activities
____ Inability to control thoughts
____ Hearing voices
____ Relationship difficulties
____ Drug abuse
____ Nightmares
____ Elevated mood
____ Tremors
____ Cutting or other self-harming behaviors
____Concerns regarding family of origin
____ Unable to say what you really think or feel
____ Angry outbursts
____ Excessive fear of specific places or objects
____ Difficulty making or keeping friends
____ Concerns about finances
____ Feeling as if you’d be better off dead
____ Difficulty making decisions
____ Loss of interest in sexual relationships
____ Concerns about emotional health/stability
____ Insomnia/difficulty sleeping
____Crying Spells
____ Uncontrollable anxiety or worry
____low self-confidence
____ Lack of motivation
____ Eating disorder
____ Excessive use of alcohol
____ Difficulty concentrating
____ Mood shifts
____ Blackouts/temporary loss of memory
____ Delusion (beliefs not based in reality)
____ History of physical/emotional/sexual abuse
____ Previous suicide attempt
____ Other (Please specify) ____

____

Who referred you to counseling? ______________________________Referral Date __________
How did you find me? ____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? Yes No
If yes, where and with regard to what concerns? _________________________________
Have you ever been diagnosed with or treated for any type of mental illness? Yes No
If yes, please list ____
Has anyone in your family ever been diagnosed or treated for any type of mental illness? Yes No
If yes, please list____

Client Initials ______

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MEDICAL HISTORY

Physician's Name ____Phone Number: ___________________________

Address____City________________________State ____ Zip ________

How would you rate your current physical health? (circle one) Excellent Good Fair Poor

Are you currently experiencing any physical problems (headaches, body aches, stomach problems, etc.)?

Yes No

If yes, please explain: ____

____

____

Please list any medical conditions or disabilities: ____

____

____

Is there anything else you would like me to know that was not asked above? _________________________________

____

____

MEDICATION(S) over-the-counter or prescription	DOSAGE	PRESCRIBING PHYSICIAN

EMERGENCY CONTACT

Name ____ Relationship ______________________________

Home Phone ______________________Work Phone ______________________ Cell Phone _______________________

Address ____ City, State, Zip __________________________________

_______________________________ _______________________________ ______________

Client Printed Name Client Signature Date Signed

_______________________________ ______________

Counselor Signature Date

Client Initials ______