TREE OF LIFE
COUNSELING SERVICES LLC

Client Intake Form

Please note: Information provided on this form is protected as confidential.

Personal Information

Name: _____ DOB: _____ Age: _____

Parent/Legal Guardian (if under 18): _____

Address: _____ Zip Code: _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell/Work Phone: _____ May we leave a message? ☐ Yes ☐ No

Email: _____ May we leave a message? ☐ Yes ☐ No

Gender: _____ Sexual Orientation: _____

Relationship Status:

☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Mental Health History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? ☐ No ☐ Yes

If yes, please list: _____

_____

Have you ever been, or are you currently taking, any psychiatric medication? ☐ No ☐ Yes

If yes, please list: _____

_____

General and Mental Health Information

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

Please list any specific health problems you are currently experiencing:

_____

Please list any specific sleep problems you are experiencing:

_____

Please list the types and frequency of exercise you participate in:

_____

Please list any difficulties you experience with your appetite or eating problems:

_____

Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes

If yes, for approximately how long? _____

_____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes

If yes, for approximately how long? _____

_____

Are you currently in a romantic relationship? ☐ No ☐ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

Substance Abuse History

Do you drink alcohol more than once a week? ☐ No ☐ Yes

How often do you engage in recreational drugs?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

In the section below, mark all the substances that are abused and answer the following questions.

☐ Alcohol	☐ Cocaine	☐ Inhalants
☐ Benzodiazepines	☐ Opiates	☐ Methadone
☐ Barbiturates	☐ Marijuana	☐ Other: _____

What was your first age of use? _____

_____

What was your method of use? _____

_____

How many times have you used the substance(s) within the last 30 days? _____

_____

How frequently do you use the substance(s)? _____

_____

Within an average 24-hour period, how much of the substance(s) do you use? _____

_____

When was your last usage of the substance(s)? _____

_____

Family Mental Health History

In the section below, 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.

Alcohol/Substance Abuse	☐ No ☐ Yes	_____
Anxiety	☐ No ☐ Yes	_____
Depression	☐ No ☐ Yes	_____
Domestic Violence	☐ No ☐ Yes	_____
Eating Disorders	☐ No ☐ Yes	_____

Obesity ☐ No ☐ Yes _____

Obsessive Compulsive Disorder ☐ No ☐ Yes _____

Schizophrenia ☐ No ☐ Yes _____

Suicide/Suicide Attempts ☐ No ☐ Yes _____

Additional Information

Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? _____

Is there anything stressful about your current work? _____

What is your current education level? _____

☐ High School ☐ Undergraduate ☐ Graduate ☐ Trade/Certification

Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

If yes, describe your faith or belief: _____

What do you consider to be some of your strengths? _____

_____

_____

What do you consider to be some of your weaknesses? _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

Is there any other information about yourself that you would like to add to this form?

_____

_____

_____