*The New Orleans Growth Center*

Individual, Couple, and Family Counseling

**CLIENT INTAKE FORM** Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_\_\_\_\_\_\_

Marital Status: □Single □Cohabitating □Married □Separated □Divorced

How long have you been married/together/separated/divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? \_\_\_Yes \_\_\_No

**List all persons in your household:**

Name Birth Date (Age) Relationship School/Place of Employment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMERGENCY CONTACT:**

Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING PROBLEM:**

Please describe the main difficulty that has brought you to seek help:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long has this issue been of concern to you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your hope in our talking together? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUPPORT SYSTEM/ RESOURCES:**

Describe your support system and resources: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EDUCATION AND WORK HISTORY:**

Schooling (highest level completed):

□Elementary school □High School □College □Post College □Trade School □GED

Describe current job if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HEALTH HISTORY:**

Do you or any member of your family (parent, sibling, grandparent or other immediate family member) have a history of any medical health issues? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Care Doctor/Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH HISTORY:**

Have you received counseling or therapy before? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_ psychiatrist \_\_\_\_ psychologist \_\_\_\_ social worker \_\_\_ minister \_\_\_ counselor

Do you or any member of your family (parent, sibling, grandparent or other immediate family member) have a history of any medical health issues? \_\_\_Yes \_\_\_No

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for mental health problems? \_\_\_\_ Yes \_\_\_\_No

If yes, please explain (include name of hospital and dates) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been physically, verbally, mentally, or sexual abuse? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Suicidal Ideations? Current: \_\_\_\_ Yes \_\_\_\_ No Past \_\_\_\_ Yes \_\_\_\_ No

Homicidal Ideations? Current: \_\_\_\_ Yes \_\_\_\_ No Past \_\_\_\_ Yes \_\_\_\_ No

MEDICATION HISTORY:

Please list any medications you are currently taking or have taken in the past, listing most recent first. Please provide prescribing physician's name.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Medication  | Dosage | Purpose | Start/ End Date  | Prescribing MD |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**SUBSTANCE ABUSE HISTORY:**

Do you use alcohol? \_\_\_\_ Yes \_\_\_\_ No How much? \_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_

Do you use drugs? \_\_\_\_ Yes \_\_\_\_ No How much? \_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_

Do you feel alcohol and/or drugs are a problem for you? \_\_\_\_ Yes \_\_\_\_ No

**MILITARY HISTORY:**

Have you ever served in the military? \_\_\_\_ Yes \_\_\_\_ No What Branch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_