Client Intake Information

Please fill this form out to the best of your ability. If you aren't sure how to answer a question, leave it blank and discuss it with your counselor.

Name: _____ _____ _____
(Last) **(First)** **(MI)**

Birth Date: _____ / _____ / _____ **Age:** _____ **Soc. Sec.:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender**

How did you hear about us? _____

Home Address:_____

City: _____**State:** _____ **Zip:** _____

Email: _____ **@** _____

Primary Phone: _____ - _____ - _____ **May we leave a leave message?** ☐ **yes** ☐ **no**

Alternate Phone: _____ - _____ - _____ **May we leave a leave message?** ☐ **yes** ☐ **no**

Emergency Contact: _____ / _____ - _____ - _____

Relationships:	**Ethnicity:**	**Education:**
☐ **single**	☐ **American Indian**	☐ **Some High School**
☐ **separated**	☐ **Asian**	☐ **High School Degree**
☐ **domestic partner**	☐ **Black**	☐ **Some College**
☐ **divorced**	☐ **Hispanic**	☐ **Associates Degree**
☐ **married**	☐ **Pacific Islander**	☐ **Bachelors Degree**
☐ **widowed**	☐ **White**	☐ **Masters Degree**
Children: ☐ **Yes** ☐ **No**	☐ **Other** _____	☐ **Doctorate**

Occupation: _____Employer: _____

Spiritual Practice/Religious Affiliation (optional): _____

1.The concerns that brought me to counseling today are (Check the items that apply to you):

□ Depression	□ Stress	□ Racing thoughts	□ Past physical abuse
□ Low energy	□ Anxiety/ worry	□ Trouble focusing	□ Present physical abuse
□ Low self-esteem	□ Panic attacks	□ Easily agitated	□ Past sexual abuse
□ Poor concentration	□ Heart racing	□ Spending too much	□ Current sexual abuse
□ Hopelessness	□ Chest pain	□ Gambling	□ Past trauma
□ Worthlessness	□ Feeling shaky	□ Risky sexual behavior	□ Recent trauma
□ Guilt	□ Sweating/ chills	□ Delusions	□ Nightmares
□ Sleeping too much	□ Feeling on edge	□ Hallucinations	□ Easily startled
□ Sleeping too little	□ Can't relax	□ Not thinking clearly	□ Flashbacks
□ Thoughts of hurting self	□ Fear of dying	□ Feeling like things are unreal	□ Decreased interest in sex
□ Thoughts of hurting others	□ Feeling fearful	□ Losing track of time	□ Low interest in activities
□ Isolation/ withdrawal	□ Nausea	□ Unpleasant thoughts	□ Avoiding people & places
□ Feelings of sadness	□ Obsessive thoughts	□ Anger/ Frustration	□ Concern about loved one
□ Grief/ loss	□ Compulsive behaviors	□ Conflict with others	□ Feeling out of sorts

2. Other concerns that are not listed above?

_____

_____

3. Please rate your current level of concern or stress on a scale from 0-10, 0 being no distress and 10 being extremely distressed. (circle one)

0 1 2 3 4 5 6 7 8 9 10

4. Have you ever seen a counselor, social worker, psychologist, or psychiatrist? □ Yes □ No
If so, when and for what concerns?

_____

_____

5. **Have you ever been diagnosed with a mental or emotional disorder? □ Yes □ No**
If so, what was the diagnosis?

_____

When were you diagnosed? _____

Who made the diagnosis? _____

6. **Have you ever been hospitalized for mental health concerns? □ Yes □ No**
If so, when and where:

_____

_____

7. Please list current medications you are taking:

Current Prescribed Medication	**Dose & Frequency**	**Purpose**	**Side Effects**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Current Over-The-Counter Medication	**Dose & Frequency**	**Purpose**	**Side Effects**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Are you currently, or have you ever attended self-help or support groups? □ Yes □ No
If so, please list groups attending or attended:

_____

_____

9. Please check any of the following challenges that currently apply to you:

Relationship:
□ Significant other
□ Aging/ ill parents
□ Family
□ Friends
□ Children
□ Other: _____

Financial:
□ Recently filed bankruptcy
□ Credit card debt
□ Paying rent/ mortgage
□ Paying for medical needs
□ Other: _____

Physical:
□ Diabetes
□ Heart Disease
□ High blood pressure
□ Muscle/ joint / back pain
□ Problems sleeping
□ Challenges with weight
□ Sexual problems
□ Other: _____

Occupational:
□ Challenges with supervisor
□ Challenges with coworkers
□ Challenges performing job tasks
□ Feeling bored or uninterested in work
□ Down-sizing or lay off
□ Disciplinary action taken against you
□ Fired or suspended in the past
□ Other: _____

8. Are you currently under the care of a Primary Care Physician? □ Yes □ No
If so, please list your doctor's name:

_____

9. Check any of the following changes that you have experienced in the past year:

□ Divorce/ Separation
□ Death of loved one
□ Change in job
□ Birth of child
□ Parent moving to nursing home
□ Breakup with significant other
□ Moved
□ Change in significant other's job
□ Child moving out of the home
□ Loved one deployed

□ Parent moving into home w/ me
□ Close friend/ family member moved
□ Diagnosed with a medical condition/ change in your health
□ Significant other/ loved one diagnosed with a medical condition
□ Other: _____

10. Check any of the following that currently apply to you:

- □ Family history of drug or alcohol problems
- □ Personal history of drug or alcohol problems
- □ Current concerns about your drinking
- □ Current concerns about your drug use
- □ Current drinking or drug use affecting your job or other important activities
- □ Family or loved one's concerned about your drinking or drug use
- □ Current concerns about a loved one's drinking or drug use
- □ History of gambling problems
- □ Current concerns about your gambling
- □ Current concerns about a loved one's gambling
- □ History of risky or excessive sexual behavior
- □ Current concerns about your sexual behavior

11. Any current legal issues or problems at this time? □ Yes □ No
If so please describe:

_____

_____

12. Have you currently or have you ever served in the military? □ Yes □ No
If so, what branch & when did you serve? _____

13. Any other information that will be helpful for us to know about you?

_____

_____

_____

14. What do you hope to achieve by attending counseling?

_____

_____

_____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____