Clarke Counseling & Psychological Services

CONFIDENTIAL

Intake Form

Client First and Last name: _____ Today's Date: _____

Client Date of Birth: _____ Age: _____ Male: _____ Female: _____ Transgender: _____

Home Address: _____
Street

_____
City State Zip

Home Phone: _____ Is it OK to contact you at home? _____ OK to leave a message? _____

Cell Phone: _____ Is it OK to contact you on cell? _____OK to leave a message? _____

Email Address: _____ Who referred you? _____

Please list the reason(s) for seeking help:

1. _____

2._____

3._____

Please list the symptoms that you are currently experiencing and the intensity:

	Mild	Moderate	Severe			Mild	Moderate	Severe
Anger					Low energy/fatigue			
Anxiety					Memory impairment			
Attention, Concentration, Distractibility					Mood swings			
Avoidance					Nightmares/Recurring dreams			
Addictive/Reckless Behaviors (e.g., gambling, pornography)					Oppositional Behavior			
Bingeing					Obsessive Thoughts			
Difficulty making decisions					Physical Aches and pains			
Decreased/Increased need for sleep					Paranoia			
Delusions					Perfectionism			
Divorce					Relationship problems (with friends, coworkers)			
Excessive guilt					Racing Thoughts			
Excessive Energy					Reduced/Increased Appetite			
Failure					Self-harm (cutting, burning)			
Grief/Loss					Suicidal thoughts/behaviors			

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	Mild	Moderate	Severe			Mild	Moderate	Severe
Forgetfulness					Substance abuse/dependence			
Hearing Voices					Sexual Problems			
Isolation/Withdrawal					School problems			
Impulsivity					Startle more easily			
Inability to sit still					Stealing			
Increased irritability					Tearfulness			
Irrational fears					Trauma (physical, emotional, sexual)			
Judgement problems					Thought disorganization, confusion			
Lying					Worry			
Loss of interest in pleasurable activities					Work problems			
Lightheadedness/Fainting					Worthlessness			

SUICIDE RISK ASSESSMENT

1. In the past few weeks, have you wished you were dead? □ Yes □ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? □ Yes □ No
3. In the past week, have you been having thoughts about killing yourself? □ Yes □ No
4. Have you ever tried to kill yourself? □ Yes □ No If yes, how? _____ When? _____
5. Are you having thoughts of killing yourself right now? □ Yes □ No

EMOTIONAL AND PSYCHIATRIC HISTORY

Have you ever had prior outpatient treatment? □ Yes □ No, If Yes

Reason for Treatment	Dates Treated	By Whom or Where

Have you ever had prior inpatient treatment? □ Yes □ No, If Yes

Reason for Treatment	Dates Hospitalized	By Whom or Where

Are you currently taking any psychiatric medication? □ Yes □ No, If Yes, please list

Current medication	Dosage & Frequency	What is it prescribed for	Prescribing Physician

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Please list past psychiatric medications if any and what they were prescribed for:

Past medication	What was it prescribed for	Prescribing Physician	Was it Helpful?

MEDICAL HISTORY

Are you currently under treatment for a medical condition? □ Yes □ No, If Yes

Name of Condition	Medication	Provider

Have you ever had surgeries, hospitalizations for serious injuries or illness? □ Yes □ No
If Yes Briefly describe (What, where, when)

_____

_____

Have you ever blacked out / lost consciousness and/or experienced any type of serious head injury or trauma? □ yes □ no

If Yes, please indicate when and what happened

_____

List all medications that you currently take:

Medication	Dosage	Prescribing Physician	Has it been helpful

FAMILY HISTORY (has anyone in your family ever been treated for any of the following)? Check all that apply

	Father	Mother	Grandparent	Sibling	Children	Other
Depression			☐ Maternal ☐ Paternal			
Anxiety			☐ Maternal ☐ Paternal			
Panic Attacks			☐ Maternal ☐ Paternal			
Bipolar			☐ Maternal ☐ Paternal			
Schizophrenia			☐ Maternal ☐ Paternal			
Alcohol problem			☐ Maternal ☐ Paternal			
Drug problem			☐ Maternal ☐ Paternal			

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	Father	Mother	Grandparent	Sibling	Children	Other
ADHD			☐ Maternal ☐ Paternal			
Suicide Attempt			☐ Maternal ☐ Paternal			
Posttraumatic Stress Disorder			☐ Maternal ☐ Paternal			
Psychiatric Hospitalization			☐ Maternal ☐ Paternal			

SUBSTANCE ABUSE HISTORY

Have you ever been treated for alcohol or drug abuse or dependence? □ Yes □ No

If yes, for which substances?

_____

If yes, where were you treated and when? -

_____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the greatest number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? □ Yes □ No

Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No

Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?
□ Yes □ No

Do you think you may have a problem with alcohol or drug use? □ Yes □ No

Have you used any street drugs in the past 3 months? □ Yes □ No
If yes, which ones?

_____

Have you ever abused prescription medication? □ Yes □ No
If yes, which ones and for how long?

_____

_____

Has drinking or drug use ever caused you problems in the following areas (check if yes): □ family □ school □ employment
□ legal □ emotional □ social □ financial □ behavior □ physical health

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Tobacco History:
How you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No How many packs per day on average? _____ How many years? _____
In the past? □ Yes □ No How many years did you smoke? _____ When did you quit? _____

TRAUMA HISTORY

Do you have a history of being abused emotionally, sexually, physically or by neglect? □ Yes □ No

If yes, please describe when, where and by whom:

_____

_____

Did you receive treatment? □ Yes □ No

_____

EDUCATIONAL HISTORY

Highest Grade Level Completed? _____ Where? _____

Degree Obtained _____ Where? _____Major? _____

Did you have any disciplinary problems in school? If yes, please explain

_____

Were you considered hyperactive/ADHD in school?

_____

If yes, were/are you on any medication? If so, which medication?

_____

What kinds of grades did you get in school?

_____

OCCUPATIONAL HISTORY

Are you currently: □ Working □ Student □ Unemployed □Disabled □ Retired

How long in present position? _____

What is/was your occupation?

_____

Where do you work?

_____

Are you satisfied with your current job? □ Yes □ No, If no please explain

_____

Have you ever served in the military? □ Yes □ No, If so, what was your job title in the military?

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_____

Honorable discharge □ Yes □ No Other type discharge

_____

RELATIONSHIP & CURRENT FAMILY

Are you currently: □ Married □ Partnered □ Divorced □ Single □Widowed How long? _____

If not married, are you currently in a relationship? □ Yes □ No If yes, how long?

_____

What is your spouse or significant other's occupation?

_____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? □ Yes □ No If so, how many? _____ How long for each marriage?

_____-_____

Do you have children? □ Yes □ No If yes, list ages and gender:

_____

_____

Describe your relationship with your children:

_____

What kind of social activities do you participate in?

_____

Who do you turn to for help with your problems?

_____

PERSONAL HISTORY

Where were you born and raised?

_____

Who raised you? □ Mother □ Father □ Grandparent □ Adopted Parents □ Other

_____

Did your parents ever divorce? □ Yes □ No, If yes how old were you? _____

Do you have any siblings? □ Yes □ No, If Yes please list

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Name	Gender	Age	Current Residence- State	Employment/School

List everyone who currently lives with you:

Person(s) Living with you	Age	Employment/School	Describe Quality of Relationship

LEGAL HISTORY

Have you ever been arrested? □ Yes □ No, If Yes for what
_____

Do you have any pending legal problems? □ Yes □ No If yes what
_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship _____

Address
_____
Street, Apt # City State Zip Code

Telephone # Daytime _____ Evening _____ Cell Phone_____

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