Claudia Cooper, PLLC **Client Intake Form**

Name:_____ **Today's Date:** _____

DOB_____ **Age**_____ Is client under 18 years of age? Yes ☐ No ☐ Name of Person filling out this form and reason: _____

_____

Address:_____ **City:**_____ **ST:**_____ **Zip:**_____

Mailing Address (if different): _____

Phone: (C)_____ (H)_____ (W)_____

Email: _____

May we leave a voice/text message? Yes ☐ No ☐ If yes, by ☐ cell ☐ home ☐ work ☐ email
May we send you an appointment reminder? Yes ☐ No ☐ If yes, by ☐ text ☐ v-mail ☐ email

Employer:_____ **Occupation:**_____

Are you a student? Yes ☐ No ☐ If yes, name of school: _____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

Referred by:_____ May we send them a thank you? Yes ☐ No ☐

Presenting Problem/Issues

Briefly describe the problems or issues that brought you to counseling: _____

_____

_____

When did these problems or issues develop? _____

_____

_____

What are you hoping to achieve through counseling? _____

_____

_____

Client Problem Assessment

Presenting Problem – Precipitating Stressors: "In recent months, I have been concerned about…"
Please check all that apply, past or present

☐ Marriage ☐ Spouse/Partner ☐ Parent/Child ☐ Family of Origin ☐ Extended Family
☐ Abuse (☐ physical ☐ sexual ☐ psychological ☐ neglect) ☐ Guilt ☐ Shame
☐ Cultural/Ethnic/Race ☐ Health ☐ Job ☐ Financial
Other: _____

Symptoms *Please check all that apply:*

☐ Decreased Concentration ☐ Decreased Motivation ☐ Decreased Energy
☐ Disturbance in Sleep Patterns ☐ Increased Stress ☐ Loss of Control
☐ Decreased Interest in Activities ☐ Numbness or Tingling ☐ Chest Pains / Discomfort
☐ Unexplained Physical Problems ☐ Body Tension ☐ Thoughts of Death/Suicide
Other_____

Major Life Events *Please check all that apply:*

☐ Death of a family member/friend ☐ Divorce ☐ Separation ☐ Imprisonment
☐ Personal injury/illness ☐ Marriage ☐ Job loss ☐ Pregnancy/complications
☐ Career change ☐ Legal problems ☐ Relocation ☐ Holidays ☐ Financial
Other: _____

Suicidal / Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? Yes ☐ No ☐
Is there a history of suicide/homicide in your nuclear and/or extended family? Yes ☐ No ☐
Are you presently suicidal/homicidal? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Have you ever subjected yourself to harm such as cutting, hitting, or burning? Yes ☐ No ☐
Have you ever subjected another person to physical harm? Yes ☐ No ☐
If yes, explain *(how, when, where, what method, why)*: _____

_____

Strengths and Weaknesses

Please list what you consider to be your personal strengths and weaknesses.

Strengths	**Weaknesses**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Living Arrangements

Current Address:_____How Long: _____

With whom do you live? _____

Current relationship with others where you live: _____

_____

_____

Relationship History

Sexual Orientation: _____

Are you married? Yes ☐ No ☐ If not married, are you in a relationship? Yes ☐ No ☐

Name and age of spouse/partner: _____

Date of marriage/cohabitation: _____

Previous marriage/relationship: Yes ☐ No ☐ If yes, name of spouse/partner: _____

If yes, date of divorce/end of partnership: _____

Where children involved in the previous marriage/partnership: Yes ☐ No ☐

What is your perception of the status of your *current* relationship? *(include communication patterns and problems, relationship issues, blended family issues, sexual relations, etc.)* _____

_____

_____

Name, ages, and relational history of children from marriages/partnerships.

Name	Age	Comments	Bio, Step, Adopted

Developmental History

List the members of your family of origin/adoption and your compatibility with each one now.

Family Member	Comments

What was your birth order: #_____of_____children. Who primarily raised you? _____

How would you describe your childhood? ☐ Uneventful ☐ Boring ☐ Traumatic ☐ Painful
☐ Unhappy ☐ Ignored ☐ Neglected ☐ Withdrawn ☐ Other _____

What was life like for you as a child? *(Include what you were like as a child, relationship with parents, siblings, family, and friends; hobbies, and personality.)* _____

_____

_____

_____

Did you experience any traumatic events as a child or adult? *(Include serious illness/injuries, surgeries, death of family and/or friends, natural disasters, abuse, neglect, etc.)*

Date	**Age**	**Event**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Who do you depend on for support? *(Check all that apply)*

☐ Parents ☐ Siblings ☐ Spouse ☐ Children ☐ Employer ☐ Church ☐ Pastor
☐ Therapist ☐ Extended Family ☐ Neighbor(s) ☐ Close Friend(s) ☐ Co-Worker(s)
☐ Doctor(s) ☐ Support Group(s) ☐ Community Services ☐ Other: _____

Family Involvement

Would it be beneficial for any members of your family to be involved in your treatment? Yes ☐ No ☐
If yes, explain who and why *(complete release of information consent form if needed)*: _____

_____

_____

Legal History *(Please explain all that apply, past and present)*

Charges as a minor: _____

Current Charges: _____

Arrests: _____

Convictions: _____

Parole/Probations: _____

Bankruptcies: _____

Divorce/Separation: _____

Foreclosures: _____

Civil Suits: _____

Financial Situation

Briefly describe your financial situation: _____

_____

_____

Work History

Describe your current job/career: _____

_____

What do you like or dislike about your job and/or career?

Like	Dislike
_____	_____
_____	_____
_____	_____
_____	_____

How do you deal with authority figures? Describe your relationship with supervisors and co-workers.

_____

_____

Have you ever been fired from a job? Yes ☐ No ☐ If so, please explain: _____

_____

Educational History

Describe what school was like for you: _____

_____

Highest level of education: _____ What kind of grades did you make? _____

Military History *(Please include branch, rank, activity, deployments, awards, achievements, discharge status, etc.)*

_____

Religious and Cultural Factors

Please list any issues, values, or beliefs which are important or may have affected you regarding your religion or cultural/ethnic background: _____

_____

_____

Do you have a religious/spiritual background? Yes ☐ No ☐ Preference _____
Do you attend religious/spiritual services? Yes ☐ No ☐ If so, where and how often? _____

_____

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Medical History

How would you describe your current health? _____ Are you

Name of Medication	Dosage/Frequency	Prescribing Physician

Has it been more than a year since your last physical exam, including blood work? Yes ☐ No ☐
Have you had or were you involved with an abortion? Yes ☐ No ☐ Miscarriage? Yes ☐ No ☐
List any previous health issues including surgeries, procedures, and medical hospitalizations:

Problem	Date	Treatment

Counseling History *(Please list all previous psychotherapy experiences.)*

Are you or have you ever participated in counseling or psychotherapy treatment? Yes ☐ No ☐
If yes, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

Psychiatric History *(Please list all previous inpatient / outpatient experiences.)*

Have you ever been treated by a psychiatrist/psychologist for a mental health issue? Yes ☐ No ☐
Have you ever been hospitalized for mental health related issues? Yes ☐ No ☐
Have you ever been hospitalized for mental health issues related to substance abuse? Yes ☐ No ☐
If you answered yes to any of the above, please provide as much information as possible.

Date(s)	Provider	Reason for Treatment	Results

List all psychotropic medications you have taken including those for anxiety, depression, and/or sleep: _____

_____

Has anyone in your family ever been diagnosed or treated for a mental health disorder, alcohol or drug related problem? Yes ☐ No ☐ If yes, please explain.
Has anyone in your family had problems with alcohol or drugs that was not treated? Yes ☐ No ☐
If yes, please explain.

Family member	Problem/Disorder	Treatment Results (if any)

Substance Use / Abuse History

Describe your history of current/past substance usage (including OTC, prescription, alcohol, caffeine, and tobacco).

Substance	Amount	Frequency	Age of 1st use	Age regular use started	Age last used

Have you experienced an increase in the use of alcohol and/or other substances? Yes ☐ No ☐
Do you see your usage as a problem? Yes ☐ No ☐ If yes, when did it become problematic?

_____

_____

Please describe any previous experience with substances or alcohol _____

_____

_____

Please describe any family history of substance and/or alcohol use _____

_____

_____

Do you or any of your family have compulsive or addictive behaviors such as gambling, sexual behavior, shopping, etc.? Yes ☐ No ☐ If so, please describe _____

_____

_____

Nutrition

Have your eating habits changed recently? Yes ☐ No ☐ If so, please describe _____

_____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? Yes ☐ No ☐
Do you often eat out of depression, boredom, and/or anger? Yes ☐ No ☐ If yes, please describe

_____

Do you use laxatives, water pills (diuretics), or diet medications? Yes ☐ No ☐ If so, how often and for what purpose do you use them? _____

_____

Additional Information

Is there any other information that can be helpful for us to know about you? _____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

For Office Use Only – Clinician Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Adverse Childhood Experiences Questionnaire
Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **OFTEN** . . .
Swear at you, insult you, put you down, or humiliate you?
OR
Act in a way that made you afraid that you might be physically hurt?
Yes ☐ No ☐ If yes enter 1 _____

2. Did a parent or other adult in the household **OFTEN** . . .
Push, grab, slap, pull your hair, or throw something at you?
OR
EVER hit you so hard that you had bruises, marks, or were injured?
Yes ☐ No ☐ If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **EVER** . . .
Touch or fondle you or have you touch their body in a sexual way?
OR
Try to or actually have oral, anal, or vaginal sex with you?
Yes ☐ No ☐ If yes enter 1 _____

4. Did you **OFTEN** feel that . . .
No one in your family loved you or thought you were important or special?
OR
Your family didn't look out for each other, feel close to each other, or support each other?
Yes ☐ No ☐ If yes enter 1 _____

5. Did you **OFTEN** feel that . . .
You didn't have enough to eat, had to wear dirty clothes, and had no on to protect you?
OR
Your parents were too intoxicated to care for you or take you to a doctor if you needed it?
Yes ☐ No ☐ If yes enter 1 _____

6. Were your parents **EVER** separated or divorced?
Yes ☐ No ☐ If yes enter 1 _____

7. Was your mother, stepmother, grandmother, or other significant female caretaker . . .
OFTEN pushed, grabbed, slapped, had her hair pulled, or had something thrown at her?
OR
SOMETIMES or **OFTEN** kicked, bitten, hit with a fist or hit with something hard?
OR
EVER repeatedly struck over several minutes or threatened with a gun or a knife?
Yes ☐ No ☐ If yes enter 1 _____

8. Did you **EVER** live with anyone who was a problem drinker, an alcoholic, or used drugs?
Yes ☐ No ☐ If yes enter 1 _____

9. Has a household member **EVER** been depressed, mentally ill, or attempted suicide?
Yes ☐ No ☐ If yes enter 1 _____

10. Has a household member **EVER** been arrested, gone to jail, or been in prison?
Yes ☐ No ☐ If yes enter 1 _____

Now add up your "YES" answers:_____This is your ACE score.