PEACE, LOVE & COUNSELING by Fran
Individuals, Couples, Families & Systems
Francis A. Bax, MS, LMHC, LPC, CASAC-Master
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INDIVIDUAL CLIENT INFORMATION INTAKE FORM

*****THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL*****
(PLEASE PRINT LEGIBLY AND CLEARLY!)

Today's Date: _____

Name: _____ Birthdate_____ Age _____

Sex: ☐ MALE ☐ FEMALE

Address_____

City_____ State_____ Zip_____

E-Mail Address_____

Home Phone (___) _____Work Phone (___) _____

Can a message be left with you? ☐ YES ☐ NO

Best Place to Leave a Message (___) _____

Who were you referred by? / How did you hear about me?

_____

Level of Education: ☐ HS ☐ Some College ☐ Bachelor's degree ☐ Master's Degree

☐ Doctorate/Terminal Degree ☐ Other_____

Place/Type of Employment_____

How long? _____ Full or Part time? _____

If unemployed, how long: _____

What type of work did you do? _____

Marital Status ☐ Married # of years____;

☐ Divorced # of years ___; ☐ Widowed____# of years____; ☐ Single ☐ Committed

☐ Domestic Relationship

Living with_____

Spouse's Name_____

Spouse's Occupation_____

In Case of Emergency Notify: _____ Phone: _____

Relationship: _____

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO

If yes, what were the circumstances? Please include dates:

_____

_____

When was your last full physical exam? _____

Any physical issues? _____

Please check off any of the following health problems you may have or previously had:

- ☐ Diabetes
- ☐ Heart Murmur
- ☐ Chron's Disease
- ☐ High Blood Pressure
- ☐ Pneumonia
- ☐ Colitis
- ☐ High Cholesterol
- ☐ Pulmonary Embolism
- ☐ Anemia
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Jaundice
- ☐ Goiter
- ☐ Emphysema/COPD
- ☐ Hepatitis
- ☐ Cancer
- ☐ Stroke
- ☐ Stomach/Peptic Ulcer
- ☐ Leukemia
- ☐ Cataracts
- ☐ Tuberculosis
- ☐ Angina
- ☐ Kidney Disease
- ☐ HIV/AIDS
- ☐ Heart Problems
- ☐ Kidney Stones
- ☐ Hearing Loss
- ☐ COVID-19
- ☐ OTHER

How have these health issues impacted you?

_____

Sleeping issues? ☐ YES ☐ NO

How many hours of sleep do you get each evening? _____

List any medications you are presently taking and dosage:

_____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc.)

_____

Any problems with Alcohol? _____ Drugs? _____

Do you have current thoughts of suicide? ☐ YES ☐ NO

If so, do you have a plan? ☐ YES ☐ NO

Do you have the resources to carry out a suicide? ☐ YES ☐ NO

Have you ever had thoughts about suicide? ☐ YES ☐ NO

Have you ever attempted suicide? ☐ YES ☐ NO

If yes, how many times? _____

How do you spend time relaxing?

_____

Have you ever had concerns about eating habits? ☐ YES ☐ NO

Please state the reasons for seeking counseling at this time?

_____

Have you ever been in counseling before? ☐ YES ☐ NO

For how long? _____ Was it helpful for you? ☐ YES ☐ NO

Please explain how it was helpful:

_____

Please explain how it wasn't helpful:

_____

Please explain where you left off in your therapy:

_____

Please check off the problems that you're having in your life right now or previously:

- ☐ Depressed Feelings
- ☐ Anxiety
- ☐ Poor Memory
- ☐ Financial Issues
- ☐ Stress
- ☐ Decision Making
- ☐ My Appearance/Looks
- ☐ ADHD
- ☐ Insomnia
- ☐ My Future/Ambitions
- ☐ Post-Traumatic Stress/PTSD
- ☐ Nightmares
- ☐ History of Sexual Abuse
- ☐ Headaches
- ☐ Separation
- ☐ History of Physical Abuse
- ☐ Nervousness
- ☐ Poor Energy
- ☐ History of Emotional Abuse
- ☐ Dizziness
- ☐ Feeling Inferior
- ☐ History of Trauma
- ☐ Fainting Spells
- ☐ Illicit Drug Use
- ☐ Career Choices
- ☐ Shyness
- ☐ Alcohol Use Problems
- ☐ Weight/Body Image Issues
- ☐ Stomach Trouble
- ☐ Cigarette Smoking
- ☐ Mood Swings
- ☐ Inability to Relax
- ☐ Loneliness
- ☐ Fears
- ☐ Unhappiness
- ☐ Marriage/Relationship Issues
- ☐ Poor Self-Esteem
- ☐ Fatigue
- ☐ Allergies
- ☐ Worries
- ☐ Legal Matters and Issues
- ☐ Suicidal
- ☐ Sexual Orientation and Identity
- ☐ Problems with Self-Control
- ☐ Sexual Problems
- ☐ Athletic Performance
- ☐ Poor Appetite
- ☐ Work
- ☐ Public Speaking Issues
- ☐ Concentration Problems
- ☐ Eating Issues
- ☐ Motivation Problems
- ☐ Bad Temper
- ☐ Problems with Home
- ☐ Divorce
- ☐ Ambition/Motivation Issues
- ☐ Problems with Friends
- ☐ My Thoughts
- ☐ Health Problems
- ☐ Traumatic Brain Injury
- ☐ Autism Spectrum Issues
- ☐ Death of a Spouse/Partner
- ☐ Death of a Family Member
- ☐ Death of a Friend/Associate
- ☐ Major Illness
- ☐ Major Injury
- ☐ Financial Issues
- ☐ Relocation to/from Elsewhere
- ☐ Bad Break-Up
- ☐ Job Dissatisfaction
- ☐ Bullying/Harassment at Work
- ☐ Job Loss

Did you freely choose to go for counseling? ☐ YES ☐ NO

If no, please explain who wanted you or made to go for counseling and their reasoning:

_____

Are you bound by a legal mandate to attend counseling? ☐ YES ☐ NO

If you are bound by a legal mandate, please indicate who mandated you and provide their contact information:

_____

Please explain what you expect from counseling and list one or two goals you would like to achieve:

_____

By affixing my signature, I give consent for evaluation and treatment as a client of FRANCIS A. BAX, MS, LMHC, LPC, CASAC-Master. It is agreed that either of us may discontinue the evaluation and treatment at any time and that, as a client, I am free to accept or reject the treatment provided. In the case of services to a minor under 18, I hereby affirm that I authorize services for the child under the terms of this agreement. I also understand my rights and responsibilities as a client of FRANCIS A. BAX, MS, LMHC, LPC, CASAC-Master, and agree with the terms of my rights and responsibilities.

CLIENT SIGNATURE INDICATING CONSENT FOR EVALUATION AND TREATMENT: _____ **DATE:** _____

CLIENT PRINTED NAME: _____

Name and Relationship, if other than self: _____

WITNESS SIGNATURE: _____ **DATE:** _____

FRANCIS A. BAX, MS, LMHC, LPC, CASAC-MASTER