Client Intake Form

Date___/___/___

Name: ____DOB: ____/____/_____Age_______

Gender ❑ F ❑ M ❑ Other____________________

Address: ____TX______________
street address city zip code

Phone: (Cell) _________________ (Home) ________________is it ok to leave messages? ❑ Yes ❑ No

E-mail: _____________________________________ Highest Education Attained:_________________________

Occupation: ___________________________ Place of Employment: __________________________________

Relationship Status: _________________Partner/ Significant Other's Name ______________________________

Age _______ Occupation ____

Persons Living With You

Relationship	Name	Gender	Age	Quality of Relationship
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good

Social Relationships

Check how you generally get along with other people: (check all that apply)

❑ Affectionate ❑ Aggressive ❑ Avoidant ❑ Fight/argue often ❑ Outgoing

❑ Follower ❑ Friendly ❑ Leader ❑ Shy/withdrawn ❑ Submissive

Other (specify):____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong/identify? ____________________

Spiritual/Religious

Any religious affiliations/beliefs ❑ Yes ❑ No ____________Practicing: ❑ Yes ❑ No

How important are spiritual matters to you? ❑ Not ❑ Somewhat ❑ Moderately ❑ Very

Comments____

Legal

Are you currently or have you ever been involved any **active cases** (traffic, civil, criminal)?

❑ Yes ❑ No Are you presently on probation or parole? ❑ Yes ❑ No

____

____

Military

Military experience? ❑ Yes ❑ No Combat experience? ❑ Yes ❑ No

Comments:____

Medical

List any current health problems/concerns:

____

____

Current medications/ Dose	Purpose	Side effects

Psychosocial History

Please check behaviors and symptoms which apply to you in the last four to six weeks.

- ❑ Aggression
- ❑ Alcohol dependence
- ❑ Anger
- ❑ Antisocial behavior
- ❑ Anxiety
- ❑ Avoiding people
- ❑ Chest Pain
- ❑ Porn addiction
- ❑ Depression
- ❑ Disorientation
- ❑ Distractibility
- ❑ Dizziness
- ❑ Drug dependence
- ❑ Panic attacks
- ❑ Elevated mood
- ❑ Fatigue
- ❑ Gambling
- ❑ Hallucinations
- ❑ Heart palpitations
- ❑ Compulsive Video Gaming
- ❑ Hopelessness
- ❑ Impulsivity
- ❑ Irritability
- ❑ Judgment errors
- ❑ Loneliness
- ❑ Memory impairment
- ❑ Mood shifts
- ❑ Other (specify): ______________________________________
- ❑ Phobias/fears
- ❑ Recurring thoughts
- ❑ Sexual addiction
- ❑ Sexual difficulties
- ❑ Sick often
- ❑ Sleeping problems
- ❑ Speech problems
- ❑ Suicidal thoughts
- ❑ Disorganized thoughts
- ❑ Trembling
- ❑ Withdrawing
- ❑ Worrying
- ❑ Eating disorder

Do you ever drink alcohol? ❑ Yes ❑ No If yes, what and how often?______________________
____

Use drugs? ❑ Yes ❑ No If yes, what and how often? ______________________________________

If you or anyone in your household has a history with any of the following, please select all that apply.

❑ Physical Abuse	Family member / age: ________________________________
❑ Sexual Abuse	Family member / age: ________________________________
❑ Emotional Abuse	Family member / age: ________________________________
❑ Neglect	Family member / age: ________________________________
❑ Drug Abuse	Family member / age: ________________________________
❑ Alcoholism	Family member / age: ________________________________
❑ Domestic violence	Family member / age: ________________________________
❑ Psychiatric difficulties	Family member / age: ________________________________
❑ Criminal difficulties	Family member / age: ________________________________
❑ Other: __________________	Family member / age: ________________________________

Comments:____
____

Suicide

Have you ever considered suicide? ❑ Yes ❑ No Attempted? ❑ Yes ❑ No

Have you considered suicide in the last 60 days? ❑ Yes ❑ No Attempted? ❑ Yes ❑ No

Are you currently considering suicide? ❑ Yes ❑ No

Have you ever received counseling/psychiatric treatment? ❑ Yes ❑ No

Comments:____

GOALS

What are your goals for therapy?

____
____
____
____

Additional Information

Any other information you think your counselor should know?

____
____
____
____
____

Signature_________________________________ Date________________________