Client Information Intake Date: _____

Client Information	Name _____ ☐ F ☐ M D.O.B. _____Age: _____ Address _____ SS (last 4 only)# _____ City _____ State _____ Zip Code _____ Phone # _____ Email: _____ Ethnicity: _____ Important Counseling Factor? ☐ Yes ☐ No Religious Affiliation if important Counseling Factor? ☐ Yes _____
General Information Significant Other Family & Important Friends	☐ Married ☐ Significant Other: _____ How long? _____ Others living at Home: Relationship to You: _____ _____ _____
Marital / Significant Other History	How would you describe your current relationship? [ ] It couldn't get much better [ ] We have our ups and downs but overall it is a good relationship [ ] We have some work to do on our relationship but I am optimistic [ ] I am not certain we will be able to work things out [ ] I do not want to work things out [ ] Divorced amicably [ ] Divorced with a lot of chaos and/or anger and disagreement Have children? ☐ Yes ☐ No How many/names & ages of children: _____ _____ _____ If divorced/separated, what are the arrangements for children's living situations? Is there currently any CPS involvement with the children? ☐ Yes ☐ No
Emergency, contact:	Name/Relationship_____ Phone _____

Previous Diagnosis/Medical Information and Treatment	Are you under a Physician's or Psychiatrist's Care for Mental Health? ☐ Yes ☐ No Current condition(s)/Diagnoses: _____ _____ _____ Current Medications Amount Prescribed For the following Condition _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Doctor:_____ Phone # _____ Psychiatrist _____ Phone # _____ Ok to contact Physician? ☐ Yes ☐ No Ok to contact Psychiatrist ☐ Yes ☐ No
How you feel about Counseling / Mental Health Therapy	Have you been to therapy before? ☐ Yes ☐ No What do you hope to accomplish in therapy? What traits are very important to you in your therapist? What traits would you greatly dislike in your therapist?
Rating: 0 - 5 Not at all The most	**When you are frightened which behavior do you <u>most</u> <u>lean</u> <u>toward</u>?** ☐ Fight Argue with person, become aggressive, disagreeable, pick a fight, dismissive. Become somewhat 'bullyish'
0 - 5 Not at all The most	☐ Freeze Feel absolutely incapacitated, Sleep or do nothing, drink or use drugs, watch excessive TV or play computer games
0 - 5 Not at all The most	☐ Flight Run from the problem, change jobs, change partner/friends Relocate (move), pour yourself into a frenzy of activities
0 - 5 Not at all The mot	☐ Fool around Making a joke of the situation even if it really hurts Turn toward excessive sex to make it better, Do some high-risk activity
	Are there some areas that are very frightening for you to address at this time?

History **Family of Origin** **(before age 18)** Have you experienced the following things in your childhood home?	How many siblings? _____ Ages (in comparison to yours): _____ _____ _____ _____ ☐ Chronic Illness/condition of Parent? ☐ Of a Sibling? ☐ Of Self? _____ Describe: _____ ☐ Death of Parent ☐ Death of Sibling ☐ Death of **close** grandparent or other relative ☐ Alcoholism/Drug Abuse ☐ Emotional Abuse □ Physical abuse □ Neglect ☐ Sexual abuse or manipulation ☐ Being kept from one parent (by other) ☐ Being physically abandoned by one parent or ☐ both parents In contact with one (or both) now? _____ ☐ Mental illness or serious depression of parent:_____ ☐ Suicide within the family: _____ ☐ Natural Disaster (hurricane, tornado, earthquake in which people were injured) Were you adopted? (At what age?)_____ Foster Care? (homes)_____ Would you describe your childhood home as: □ Amazingly well-balanced and happy □ Ups and downs but not seriously disruptive □ One or two incidents that were very upsetting, but ok overall □ Difficult to be in, it felt like we were walking on eggshells □ No one watched out for us or cared what we did □ One or both parents seemed often to be uncontrollably angry or abusive □ I just never felt like I belonged, or was welcome at home or loved for me Was there a scapegoat in the family? Who: _____ Was there a "good" or favored kid? Who? _____
Medical **Information** **and Treatment**	How is your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Dealing with some issues What conditions are important for us to know about: _____ _____ Who is your Primary Care Physician? Name: _____ Clinic _____ Phone No. _____

Historic and Current History (rate 0-5: 1- seldom 3 – about half of the time 5 – A considerable problem)

Common Emotional States:	0 never	1 Seldom	2 at times	3 frequent	4 a problem	5 debilitating
I seem to have lost interest in activities I used to enjoy						
I think I might drink too much sometimes						
It is just too anxiety-producing to go out to social gatherings						
I feel lost, sad and hopeless						
I often feel frustrated and on-edge						
I am pretty much an “all or nothing” thinker						
I often have intense feelings of guilt or shame						
I fear having a panic attack						
Sometimes I have more energy than I know what to do with						
I have spells of crying and weepiness for no reason						
There are times I just don’t need much, or any, sleep						
I often feel lethargic and tired						
I have poor concentration and difficulty focusing						
I often feel inadequate around others						
I wake up with nightmares of something horrible happening						
My muscles get so tensed up and I can’t relax them						
Too often I just wish I weren’t here						
I often feel like I am like a rubber band that is twisted too tight						
I have thought of how I could kill myself, but not any more						
I’ve been told I tend to think negatively						
I can’t conjure up the motivation to get important things done						
I have thoughts of how I could kill myself now						
I am spontaneous but sometimes find myself in trouble, not having thought it through first						
I am careful to do the same things the same way every time						
I feel trapped and unable to change circumstances						
I often have thoughts of harming or cutting/burning myself						
It bothers me that my self-esteem is so low						
I wish I would quit remembering scary things						
I have gained or lost weight recently for no apparent reason						
Drinking or drugs help me relax at the end of the day						
I have trouble paying attention to a task at hand						
I have trouble falling asleep due to worry						
I am too easily distracted						
I sometimes feel extreme fear and worry about falling apart						
There are times I don’t remember everything I did somewhere						
I find it hard to pay attention to a lecture						
Sometimes I think others are watching and judging me						
I find it difficult to be still and quiet much of the time						
I feel nervous, shaky or anxious too often						
I never know when I am going to feel happy or feel sad						

Previous Treatment **IMPORTANT:**	Have you ever been hospitalized for psychological concerns? ☐ Yes ☐ No For: If yes, may we contact them? (we will fill out consent for sharing of information) Where: _____ Who was your Doctor? _____ <u>Have you ever attempted suicide?</u> ☐ Yes ☐ No <u>Have you ever thought of suicide, but not tried it?</u> ☐ Yes ☐ No <u>Do you currently feel suicidal?</u> ☐ Yes ☐ No
Occupational History	What is your current employment status? [ ] Employed full time [ ] Employed part time [ ] Self-employed [ ] Full-time student [ ] Other _____ Are you satisfied with your employment? _____ Do you feel underemployed for your abilities? _____ Are you hoping to change careers or companies? _____ When are you looking at this change? _____
Educational History	When you attended junior and senior high school, were you [ ] In regular classes [ ] In advanced classes [ ] In special-tutoring classes What is your educational level completed? [ ] Less than high school [ ] GED or equivalent [ ] High school graduate [ ] Some college [ ] College graduate [ ] Some graduate school [ ] Graduate Degree [ ] Doctorate Degree

Substance Use	Do you use any of the following substances? Coffee ☐ Yes ☐ No How much per day? _____ Per week? _____ Tobacco ☐ Yes ☐ No How many per day? _____ Per week? _____ Alcohol ☐ Yes ☐ No How many per day? _____ Per Week? _____ Comments: _____ Med. Marijuana ☐ Yes ☐ No Per day? _____ Per week? _____ Other Substances: Type(s) _____ Qty: _____ Type(s) _____ Qty: _____ Type(s) _____ Qty: _____ Have you ever been to treatment for substance use/abuse? ☐ Yes ☐ No If yes, when/where/amount of time: _____
Legal Information	Are you currently dealing with the legal system for any reasons, such as divorce, child custody, alcohol or drug DUI, Other: _____ _____
Who referred you or how did you learn of practice?	Heard about at: ☐ Church/pastor ☐ Meeting ☐ Online search (internet) ☐ Online social media ☐ Radio ☐ Other _____ ☐ Through acquaintance: _____ Name of Referral: _____ Relationship to Client_____

I have given answers to the above questions to the best of my ability and have disclosed anything that I believe to be of importance to my counseling relationship and its success.

Signature of Client _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.
FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.