Initial Intake Form – New Client Information

(Please complete this form in its entirety)

- Name: _____ Home phone: _____ Cell:_____ Work:_____
- Where may I leave a message: Home:_____ Cell:_____ Work:_____ Email:_____
- Email:_____ Your age:_____ Spouse's age:_____
- Home Address: _____

  Street Apt# City State Zip
- Marital Status (Check one) _____Single ____Married ____Widowed ____Divorced ____Separated
- If married, how long? _____ Date of Marriage:_____ Spouse's Name:_____
- If divorced, how long? _____
- If 2nd or 3rd (etc) marriage, please indicate all previous marriages dates and lengths: _____
- Religious History:_____
- Education Completed: _____
- Job History and Current Job: _____
- Name of children:

Name	Gender	Age	Sch/Occup.	DOB	Married?

- What losses (death, divorce, employment, move, mate's unfaithfulness, relational break-up, bankruptcy, empty nest, abortion, health, natural or military disaster, expectations not fulfilled) have you experienced within the last 5 years?

  _____
  _____
  _____
  _____
  _____
- List all previous therapy, counseling or other treatment of individual or marital problems:

Dates	Type of Problem	Name of Professional or Agency

- Has any of the above treatment included hospitalization? Y____ N____
- Have you ever been a victim of a crime? Yes_____ No_____
- If so, have you filed with Texas Crime Victims Compensation? Yes_____ No_____

- Have you ever been arrested? Yes_____ No_____
- Briefly describe your reason for seeking counseling ***now***: _____

  _____
- What are your goals for therapy? _____

  _____

  _____
- Please list your 3 biggest worries in life at this time: 1)_____ 2)_____ 3)_____
- Were you referred? ___Y ___N If so, whom may I thank? _____
- Are you in treatment with another counselor at this time? ___Y ___N If yes, with whom? _____

  _____ at _____. How long? _____

- **Present Physical Health:**

  Very good___ Good___ Average___ Poor___ Have you had a medical examination in the past year? Y____ N____
- If yes, when _____

  Findings:_____

  _____
- List all medications you are currently taking with dosages: _____

  _____

  _____

  Prescribed by:

  _____
- Recent weight changes: Lost_____ Gained_____
- List all important past or present injuries, illnesses or disabilities:_____

  _____
- Have you ever used drugs for other than prescribed medical purposes? Yes___ No___

  If yes, please list them_____
- Have you ever had a severe emotional upset? Please explain_____

  _____
- Have you ever terminated a pregnancy? If so, when_____
- Have you ever had a miscarriage? If so, when_____

- **Family of Origin:**

  Describe your father: _____ Describe your mother: _____

  How many siblings? _____ Where did you fit in birth order?_____ Both parents in home? __Y __N

  Overall, my childhood was: ____Painful ____Uneventful ____Good

  Has anyone **in your family** been treated for psychiatric or chemical dependency problems? __Y __N

  If yes, whom?_____ For what problem? _____

➢Checklist of Concerns/Issues: Please mark any that apply and feel free to add any others at the bottom.

___abandonment (fears of being left or abandoned)
___abuse – physical, sexual, emotional, verbal, neglect of children or elderly, cruelty to animals
___aggression, violence
___alcohol use
___anger, hostility, arguing, irritability, frustration, bitterness
___anxiety, nervousness
___attention, concentration, distractibility, focus
___career concerns, goals, and choices
___childhood issues (your own childhood)
___children, child management, child care, parenting
___codependence (overly connected to another adult or feeling responsible for their feelings, actions)
___confusion
___compulsions
___custody of children
___decision making, indecision, mixed feelings, putting off decisions,
___delusions (false ideas)
___dependence
___depression, low mood, sadness, crying
___divorce, separation
___drug use – prescription medications, over-the-counter, street drugs
___eating problems – overeating, under eating, appetite issues, vomiting, laxative use
___emptiness
___failure, fear of or (believe you are a failure)
___fatigue, tiredness, low energy
___fears, phobias
___financial or money problems, debt, impulsive spending, low income
___friendships
___gambling
___grieving, mourning, deaths, losses, divorce
___guilt
___headaches, other kinds of pain
___hearing voices, feeling paranoid someone is watching you or following you)
___health – illness, medical concerns, physical problems
___inferiority feelings or insecurity
___interpersonal conflicts
___impulsiveness, loss of control, outbursts, interrupting others
___irresponsibility
___judgment problems
___legal matters, charges, suits
___loneliness
___marital conflict, distance/coldness, infidelity/affairs, remarriage
___memory problems
___menstrual problems, PMS, menopause
___mood swings
___motivation, laziness
___nervousness, tension
___obsessions, compulsions (thoughts or actions that repeat themselves)
___Occult involvement (computer games, false religions, active participant in occult, passive dabbling)
___oversensitivity to rejection
___panic or anxiety attacks
___perfectionism (fear of failing or caring what others think about you)
___people pleasing others (constantly wondering what will other think or say about you)
___pessimism
___procrastination, work inhibitions, laziness
___relational problems
___rejection, fear of
___school problems
___self-centeredness
___self-worth
___self-neglect, poor self-care
___sexual issues, dysfunctions, conflicts, desire differences
___shyness, over sensitivity to criticism

___sleep problems, - too much, too little, insomnia, nightmares, sleep walking, night terrors
___smoking and tobacco use
___stress, relaxation, stress management, stress disorders, tension
___suspiciousness
___suicidal thinking or feelings (thoughts of death and hurting yourself) (not wanting to be here anymore)
___temper problems, self-control, low frustration tolerance
___thought disorganization and confusion
___threats, violence
___un-forgiveness, bitterness, holding on to grudges
___weight and diet issues
___withdrawal, isolating
___work problems, employment, workaholism /overworking, can't keep a job, get your identity from working

Any other concerns or issues:
_____

Please look back over you have marked and choose the one or two that you most want help with:
_____

- Are you feeling suicidal? ___Yes ___No If yes, for how long have you felt this way _____?

Emergency Contact:

Name:_____

Telephone:_____

Address:_____

Relationship:_____