



# Client Intake Form

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Please complete this form to the best of your ability. The information will enable me to help you more quickly and efficiently. If any questions are unclear or you would like to discuss them further, please mark it so we can talk about it later.

Today's date: \_\_\_\_\_ Your name: \_\_\_\_\_

Sex:      Male      Female      Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Phone numbers:    Home: \_\_\_\_\_    Ok to leave message?    y/n  
                          Cell: \_\_\_\_\_    Ok to leave message?    y/n  
                          Work: \_\_\_\_\_    OK to leave message?    y/n

Occupation: \_\_\_\_\_    Highest grade/degree completed: \_\_\_\_\_

Religious Preference: \_\_\_\_\_    Referred by: \_\_\_\_\_

Marital Status:    circle one    Single    Married    Divorced    Separated

Spouse's Name: \_\_\_\_\_    How long in present relationship? \_\_\_\_\_

Primary residence with:    circle all that apply    Spouse    Child(ren)    Other \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

If single or divorced, are you seeing someone?    Yes    No

Presenting problem: What brings you here at this time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope to get out of your counseling experience? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever sought counseling for this or any other problem(s)? \_\_\_\_\_

If yes, please list the name(s) of previous therapists and the dates you received services \_\_\_\_\_

\_\_\_\_\_

**PROBLEM AREAS:**

Please indicate if any of the following are a concern or a problem right now: circle all that apply

Job	Financial	Relationship issues	Recent loss or death
Grief	Traumatic event	Self-harm	Suicidal thoughts
Parenting issues	Family issues	Aggression, violence	Eating disorder
Drug use	Alcohol use	Fatigue	Sexuality
Recovery issues	Anger, arguing, irritability	Health issues	Trust issues
Fearful dreams	Decision making/indecision	Difficulty concentrating	Sleep issues
Spiritual/faith issues	Feeling worthless	Abuse issues	Loss of interest in activities
Appetite	Emotions	Other _____	

**CURRENT SYMPTOMS:**

Please indicate if you are having difficulty with any of the following: circle all that apply

Heart racing	Cold sweats	Excessive worrying	Edgy, often stressed out
Depressed, unhappy	Low energy, fatigue	Loss of appetite, over-eating	Mood swings
Difficulty concentrating	Suicidal thoughts/impulses	Sleep difficulty	Difficulty breathing
History of depression	Hyperactivity	Visual hallucinations	Compulsive behaviors
Trembling	Diarrhea, vomiting	Fear of leaving house	Low self-esteem
History of panic attacks	Sense of hopelessness	Anxiety	Excessive guilt
Fear of _____	Seizures	Lack of motivation	Auditory hallucinations
Grandiose plans	Abnormal body sensations	Feeling of not needing sleep	Feeling things not real
Trouble remembering	Feeling others plotting against you		

Have any of the above problems/symptoms persisted for 6 months or more? Yes No  
If so, which ones: \_\_\_\_\_

Do the above symptoms occur in more than one setting? Yes No Where? \_\_\_\_\_

Have you expressed any thoughts (even jokingly) about self harm? Yes No  
Explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever attempted suicide? Yes No (If so, please complete below)

How many times have you thought about suicide? \_\_\_\_\_

What plans have you considered to commit suicide? \_\_\_\_\_

At this time, do you have a plan to commit suicide? \_\_\_\_\_

When was the last time you considered suicide? \_\_\_\_\_

**FAMILY/BACKGROUND INFORMATION:**

Where were you born? \_\_\_\_\_

Were you raised in the same area? \_\_\_\_\_

Please list the people presenting living in your home:

Name	Age/Sex	Relation	Occupation	Years in residence
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Please list the names and ages of children or step children not living in your home:

Name	Age/Sex	Relation
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How would you describe your childhood? \_\_\_\_\_

Is your father living? \_\_\_\_ List his age, occupation, and living arrangements: \_\_\_\_\_

If deceased, list your age at the time of his death and the cause and/or circumstances of his death: \_\_\_\_\_

Describe briefly your relationship with him: \_\_\_\_\_

If you were raised in part by a step-father or significant other male, describe your relationship with him: \_\_\_\_\_

Is your mother living? \_\_\_\_ List her age, occupation, and living arrangements: \_\_\_\_\_

If deceased, list your age at the time of her death and the cause and/or circumstances of her death: \_\_\_\_\_

Describe briefly your relationship with her: \_\_\_\_\_

If you were raised in part by a step-mother or significant other female, please describe your relationship with her: \_\_\_\_\_

Did your parents divorce when you were a child?    Yes    No

If so, how old were you when they were divorced? \_\_\_\_\_

With whom did you live after the divorce?    Mother    Father    Other \_\_\_\_\_

Please list any subsequent marriages and divorces of your parents and your reaction to them:

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List the first names and present ages of any brothers and/or sisters of yours. Also note if any are deceased: \_\_\_\_\_

History of abuse or trauma in childhood? \_\_\_\_\_

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History of drug or alcohol abuse problems in your family? Yes No If so, please explain:

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History of mental or emotional problems in your family or origin? Yes No If yes, please describe: \_\_\_\_\_

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Anything else you think would be useful for your counselor to know about your childhood?

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Did you ever witness domestic violence? Yes No If yes, please explain: \_\_\_\_\_

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Were you exposed to any pornography or sexual activity (witnessed or participated in) before puberty? Yes No If so, what age and what type of exposure? \_\_\_\_\_

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### **MEDICAL HISTORY:**

Are you currently taking any medications? Yes No If so, please list medications, how long you've been taking them, who prescribes them. \_\_\_\_\_

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Do you have a primary care physician? Yes No Doctor's name: \_\_\_\_\_

Do you see any specialists? Yes No Doctor's name: \_\_\_\_\_

If yes, please state reason: \_\_\_\_\_

Have you ever been hospitalized? Yes No If so, for what reason \_\_\_\_\_

Have you missed a significant amount of work due to illness? Yes No

Have you taken any psychiatric medications in the past? Yes No If so, which ones? \_\_\_\_\_

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Are you currently taking any non-prescription medications or herbal supplements? Yes No  
If so, what are they? \_\_\_\_\_

How much sleep do you usually get? \_\_\_\_\_ hrs/night

How often do you exercise? \_\_\_\_\_ What sort of exercise? \_\_\_\_\_

Any past or present medical problems? If so, please describe: \_\_\_\_\_

Any history of head injuries or seizures? Yes No

**HISTORY OF ALCOHOL OR DRUG USE:**

Do you smoke or use tobacco? Yes No

Do you currently use drugs or alcohol? Yes No

If so, what sort? \_\_\_\_\_

When you drink, how much/how often? \_\_\_\_\_

Is this more or less than you drank in the past? More Less

How often have you become intoxicated in during the past 6 months? \_\_\_\_\_

Have you ever tried to quit drinking or cut down? Yes No

Has anyone ever complained about your drink/drug use? Yes No

Have you ever used alcohol or a drug to get going in the morning? Yes No

Have you ever had a problem taking more of a Rx drug than prescribed? Yes No

Have you had a drug or alcohol problem in the past? Yes No

Began drinking at age \_\_\_\_\_ Began using drugs at age \_\_\_\_\_

In the past I have used the following drugs \_\_\_\_\_

Have you been treated for a drug or alcohol problem? Yes No

Are you currently in a recovery program? Yes No

What is your average caffeine intake per day (coffee, tea, soda pop)? \_\_\_\_\_

**FAMILY MENTAL ILLNESS HISTORY:** Please list if any family members-siblings, aunts, uncles, cousins, parents, or grandparents been diagnosed with the following:

Depression? \_\_\_\_\_

Post-traumatic stress disorder (PTSD)? \_\_\_\_\_

Panic or Anxiety? \_\_\_\_\_

Borderline Personality? \_\_\_\_\_

Bi-Polar Disorder? \_\_\_\_\_

Schizophrenia or Schizo-affective disorder? \_\_\_\_\_

Attention Deficit Disorder (ADD/ADHD)? \_\_\_\_\_

Delayed language or speech development? \_\_\_\_\_

**LEGAL AND MENTAL HEALTH HISTORY:**

Have you ever had problems with the law/involvement with the legal system? Yes No

If so, please describe \_\_\_\_\_

\_\_\_\_\_

Are you currently involved with the legal system? Yes No If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Have you had counseling or psychiatric hospitalizations before? Yes No

If so, please list provider or clinic and give approximate dates: \_\_\_\_\_

\_\_\_\_\_

**SPIRITUAL HISTORY/BACKGROUND**

Please describe your religious upbringing \_\_\_\_\_

\_\_\_\_\_

Please describe your current spiritual interests and/or involvement \_\_\_\_\_

\_\_\_\_\_

Would you like prayer and/or Bible scripture incorporated in your counseling sessions?

\_\_\_\_\_

Anything else you would like your counselor to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_