Client Intake Form

Please provide the following information. Please complete as thoroughly as possible. Information you provide here is held to the same standards of confidentiality as our therapy.

Full Legal Name:

____

Preferred Name:

____

Proper Pronouns [How would you like to be referred to? ("he/his" "she/her" "it" "they")]

____

Name of parent(s)/guardian(s) if you are a minor:

____

Presenting Problem [Why have you come to counseling?]:_______________________________________

Referral Source:____

Birth Date: ______ /______ /______ **Current Age:** ___________ *(REQUIRED FOR RENDERING OF SERVICES)*

Social Security Number: __ __ __ - __ __ - __ __ __ __ *(REQUIRED FOR RENDERING OF SERVICES)*

Gender Identity: □ Male □ Female □ Assigned Male at birth - Female □ Assigned Female at birth - Male □ Bi-Gender □ Tri-Gender □ Poly-Gender □ Gender Neutral □ Non-Binary □ Exploring □ Other ______

Orientation *(optional)*: □ Heterosexual □ Homosexual □ Bisexual □ Pansexual □ Asexual □ Demisexual

□ Other _____________

Race/Ethnicity *(optional)*: □ Caucasian □ African American □ Asian □ Hispanic/Latino

□ Native American □ Pacific Islander □ Other _____________

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

□ Open Relationship □ Other _____________

Number of Children: ___________________

Ages and Names of Children:

____

____

Local Address:

Street:____City______________________
State:__________________Zip:__________________ *(REQUIRED FOR RENDERING OF SERVICES)*

Cell/Other Phone: (   ) ________________________________ *(REQUIRED FOR RENDERING OF SERVICES)*
May we leave a voice message? □ Yes □ No **May we send a text message?** □ Yes □ No

E-mail:____ **May we email you?** □Yes □No

Emergency Contact Information (*Who can we contact in case of an emergency?*

(REQUIRED FOR RENDERING OF SERVICES)

Name:_________________________________Relation:____________________Number:_____________________

Name:_________________________________Relation:____________________Number:_____________________

Name:_________________________________Relation:____________________Number:_____________________

***May we contact this emergency contact person and inform them of the emergency and your location if necessary*? <u>Please initial and date below:</u>**

Yes ____________ Date:______________

**Please be aware that text and email might not be confidential*

CURRENT CONCERN

What are your current symptoms?

____

____

How long have you felt these symptoms?

____

____

PERSONAL PSYCHIATRIC HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?

□ Yes □ No

Explain your previous experiences with psychotherapy: □ N/A

____

____

Name of current and/or previous therapists: □ N/A

____

____

Have you received previous care for the treatment of substance use/abuse (outpatient or inpatient)?

□No □Yes

Previous substance treatment facilities attended: □ N/A

____

Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

Have you ever experienced any of the following?

Extreme depressed mood: □ No □ Yes

Wild Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes

Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes

Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes

Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes

Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes

Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes

Body Image Problems: □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

Repetitive Behaviors: □ No □ Yes

Homicidal Thoughts: □ No □ Yes

Suicide Attempt: □ No □ Yes

TRAUMA HISTORY

Have you experienced any past traumatic events?

____

____

When did they occur?

____

____

FAMILY PSYCHOLOGICAL HEALTH

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that applies and list family member, e.g., Sibling, Parent, Uncle, etc.):

Depression: □ No □ Yes ____

Bipolar Disorder: □ No □ Yes ____

Anxiety Disorders: □ No □ Yes ____

Panic Attacks: □ No □ Yes____

Schizophrenia: □ No □ Yes ____

Substance Abuse: □ No □ Yes ____

Eating Disorders: □ No □ Yes ____

Learning Disabilities: □ No □ Yes ____

Trauma History: □ No □ Yes ____

Suicide Attempts: □ No □ Yes ____

HEALTH/MEDICAL

Do you have any allergies? □ Yes □ No

If you have allergies, to what substance(s)?

____

____

Do you smoke? If yes, how many cigarettes per day?

____

____

Do you or your partner(s) use drugs? If yes, how much, how often?

____

____

How is your physical health at present? *(Please circle)*

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

____

____

Do you have a doctor you usually see for medical services? If so, write his or her name and number below:

____

____

When was the last time you had a general medical checkup?

____

____

Are you pregnant? □ Yes □ No

If you are pregnant, how many months along is your pregnancy?

____

Are you currently being treated for any health problems or recovering from any injury, surgery, etc.? If so, briefly describe here:

____

____

Have you in the past been treated for any health problems or any injury, surgery, etc.? If so, briefly describe here:

____

____

Are you having any problems with your sleep habits? □ No □ Yes

If you are experience sleep troubles, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other ________________

How many times per week do you exercise? ______________

Approximately how long each time? ____________________

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable:

□ Eating less □ Eating more □ Binging □ Restricting □ Other ________________

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? _________________________

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

CURRENT MEDICATIONS

Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No

If yes, please list all prescription medications you currently take and for what reasons (see chart below):

Current Medications	For what condition?	Dosage (How much?)	Frequency (How often?)	Started taking When?	Comments/Problems/Concerns

Past Medications / For what conditions? (List sedatives, pain medications, sleeping pills, antidepressants, etc.):

____

SUBSTANCE USE HISTORY

Drug Type Used	Age of First Use	Date Last Used	Typical Amt. Used	Most Used in 1 Day
Alcohol				
Marijuana				
Cocaine				
Heroin				
Hallucinogens				
Amphetamines/ Methamphetamine				
Inhalants				
OTC Medications				
RX Medications				
Other				

What is your substance of choice (*does not have to be related to addiction issues*)?

____

____

Why do you use substances (*does not have to be related to addiction issues*)?

____

____

Longest period of sobriety (*does not have to be related to addiction issues*)?

____

____

Is anyone concerned about your substance use?

____

____

Do you feel you have any addictions aside from drugs or alcohol (gambling, pornography, compulsive spending, food, etc.)?

____
____

FAMILY RELATIONSHIPS

Number of/Name/Gender/Ages of Siblings:

____
____
____

Birth order (are you the youngest, middle, oldest?):

____
____

Quality of current relationship with mother:

____

Quality of current relationship with father:

____

Quality of current relationship with siblings:

____
____

Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

____

SOCIAL/RELATIONSHIPS

Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship?

____

Optional: **Please describe your sexual orientation and the role/relevance/importance of this to your life and therapy:**

____

How would you rate/describe the quality of your current relationship?

____

How many marriages have you had and how old were you when you married/divorced?

____

____

Who lives in your home with you? List names, ages, and relation to you:

____

____

____

In the last year, have you experienced any significant life changes or stressors, please list:

____

____

____

Estimate how many hours per day you spend online (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______ Work/School: ______ Other: ______

Do you feel your technology use is balanced and health or could it use improvement? Please explain:

____

____

DEVELOPMENTAL HISTORY

How would you describe your physical and psychological development growing up? Any learning disorders?

____

____

EDUCATION/CAREER

What is the highest level of education you have attained?

□ High School □ Associate □ Bachelor □ Master □ Doctorate □ Vocational □ Other

What are your educational goals?

____

____

____

What are your career goals?

____

____

____

EMPLOYMENT

Are you currently employed? □ No □ Yes

If yes, who is your current employer/position?

____

____

If yes, what are the positives of your current position?

____

____

Please list any negatives or work-related stressors at your current position, if any:

____

____

RELIGION

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your faith?

____

If no, do you consider yourself to be spiritual? □ No □ Yes

What role does religion/spirituality play in your life?

____

LEGAL HISTORY

Have you ever been arrested? □ No □ Yes

Have you ever been charged and/or pled guilty to any misdemeanors or felonies? □ No □ Yes

If yes, what were the charges?

____

____

____

OTHER

What do you consider to be your strengths?

____
____
____

What do you consider to be your limitations?

____
____

What do you like most about yourself?

____
____

What are effective coping strategies that you've learned?

____
____

What are your goals for therapy?

____
____

What are you expectations or pre-conceived notions of the therapeutic process?

____
____

DOMESTIC VIOLENCE CLIENTS ONLY:

If you are here for a domestic violence related incident, please briefly describe the incident/event: