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Chrysalis Behavioral Therapy and Counseling

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Client Intake Form

Name of Client **Name of Legal Guardian (if client is a minor)**		**Today's Date**
Client Address **Address of Legal Guardian if different from Client**		**Client Date of Birth** *Age*
City State Zip	**Preferred Phone Number:** **Okay to leave Message?** Y N **Okay to text?** Y N	**Client Marital Status:** *(circle)* Single Married Divorced Widowed Separated
Email Address? **Okay to use for communication with you?**	**Alternate Phone:** Cell Home Work **Okay to leave Message?** Y N **Okay to text?** Y N	**<u>If Client is a Minor:</u>** **Parent's Marital Status:** (circle) Single Married Divorced Widowed Separated

What brought you to counseling today?

Referral Information
How did you hear about this practice (who referred you)?
Are you currently involved with a pending or active legal suit (Probation, CPS, etc.)? YES NO If YES, who? If YES, please complete the Legal and Court Status Information Form Attached
Are you currently seeking counseling services elsewhere? YES NO
Employment Information
Employer (if unemployed, list most recent employer, If Student, provide school name & grade)
Employment Status: Student Unemployed Full-Time Part-Time Volunteer Retired

Family

Name	Relation	Age	Living (Y/N)	In Home? (Y/N)	Brief description of any mental or substance use history?

Please circle the symptoms you have experienced in the last month (cont'd on next page)

Crying spells	Fast heartbeat	Money problems
Unable to have fun	Always worried	Relationship concerns
Feelings easily hurt	Frequent sweating	Work difficulties
Lacking in confidence	Dizziness	Sexual problems
Constipation	Shaky hands	Can't hold a job
Feeling grouchy	Stomach trouble	Excessive drinking
Always tired	Nightmares	Excessive medication use
Poor appetite	Feeling tense	Excessive drug use
Depressed	Cold feet and hands	Problems with children
Trouble sleeping	Feeling panicky	Problems with parents

Feeling lonely	Diarrhea	Poor physical health
Loss of weight	Shy with people	Fighting and quarreling
Not enjoying things	Muscle twitching	Dislike my body
Suicidal thoughts	Nausea or vomiting	Full of energy
Loss of sexual interest	Can't make decisions	Overly ambitious
No one understands me	Can't make friends	Easily excited
Worried about health	Headaches	Quick tempered impatient with people Binge eating
Can't concentrate	Fainting spells	Very restless
Can't "get going"	Unable to relax	Feel like hurting someone
Feeling angry	Feeling fearful	Feel like smashing things
Don't like being alone	Overly sensitive	Excessive overeating
Lack of energy	Anxious inside	Thoughts of hurting myself
	Weight gain	Other: _____

Medical Information

Overall Physical health	**Excellent Very Good Good Fair Poor Bad**		
Date of Last Physical		**Currently being seen by a medical doctor?**	**YES NO**
Have you ever experienced a head injury, concussion or loss of consciousness?		**If YES, how many times?**	

List your <u>current</u> medical prescriptions including vitamins, supplements & hormone therapies

Please inform your counselor if this list changes over time. Use the back of this page as needed

Name	Reason	Dosage/Day

Have you taken any anti-depressant or anxiety drugs in the past?
YES NO

Have you ever been hospitalized for mental health or substance related issues?
YES NO
If YES, please provide the following

Place	Reason	Dates	Discharge Status *(ex: left against medical advice, completed program, ran out of insurance)*

I have made every effort possible to provide the most current and accurate information on this form and understand I am responsible for informing my counselor of any updates.

Client
Signature_____
Date_____