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**Client Intake Form**

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| --- | --- |
| **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  | **If Client is a Minor:** **Parent’s Marital Status:** (circle)   Single Married  Divorced Widowed  Separated   |
| **What brought you to counseling today?**  |  |
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| **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?**  |
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| **Please circle the symptoms you have experienced in the last month**  |
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|  | Crying spells Unable to have fun Feelings easily hurt Lacking in confidence Constipation Feeling grouchy Always tired Poor appetite Depressed Trouble sleeping  | Fast heartbeat Always worried Frequent sweating Dizziness Shaky hands Stomach trouble Nightmares Feeling tense Cold feet and hands Feeling panicky  | Money problems Relationship concerns Work difficulties Sexual problems Can’t hold a job Excessive drinking Excessive medication use Excessive drug use Problems with children Problems with parents  |  |

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