# CLIENT INFORMATION INTAKE FORM

***THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL***

(PLEASE PRINT CLEARLY)

Today's Date: _____

Name: _____Birthdate_____Age_____

Address_____

City_____ State_____ Zip_____

Mobile Phone (___) _____Work Phone ( ) _____

Gender _____ Email: _____

Can we leave a message? Yes No Best Place to Leave a Message _____

Who were you referred by? _____

Level of Education: HS___College____Other___

Place/Type of Employment_____ If unemployed, how long: _____

What type of work did you do? _____

Marital Status (Parents if for a child) married____# of years____; divorced___# of years ___;

widowed____# of years____; single____;living with_____

Spouse's Name_____Spouse's Occupation_____

CHILDREN (SIBLINGS IF FOR A YOUTH)

| NAME | BIRTHDATE | GENDER |
|---|---|---|
| | | |
| | | |
| | | |

**In Case of Emergency Notify: _____ Phone: _____**

**Relationship: _____**

Have you ever been hospitalized for psychiatric reasons? Y N If yes, what were the circumstances? _____

Please include dates: _____

When was your last full physical exam? _____

Any physical issues? _____

Sleeping issues? Y N How many hours of sleep to you get each evening? _____

List any medications you are presently taking and dosage: _____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc)

_____

_____

Any problems with Alcohol? _____Drugs? _____

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Do you have current thoughts of suicide? Yes No If so, do you have a plan? Yes No

Have you *ever* had thoughts about suicide Yes No

Have you ever attempted suicide? Yes No If yes, how many times? _____

How do you spend time relaxing? _____

Have you ever had concern about eating habits? Yes No

**Reasons for seeking counseling at this time.** _____

_____

_____

**Have you ever been in counseling before**? Y N For how long? _____

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Was it helpful? Y N Please explain: _____

**Is this your choice for counseling? (if no, please explain) _____**

**_____**

**Please Check Any of the Following Conditions That Currently Apply to You**

| | | | |
|---|---|---|---|
| ___Headaches | ___Nervousness | ___Dizziness | ___Fainting Spells |
| ___Shyness | ___Stomach Trouble | ___Relaxation | ___Stress |
| ___Anxiety | ___Fatigue | ___Legal Matters | ___Self Control |
| ___No Appetite | ___Anger | ___Memory | ___Making Decisions |
| ___Insomnia | ___Nightmares | ___Separation | ___Energy |
| ___Inferiority | ___Take Sedatives | ___Drug Use | ___Loneliness |

___Bowel Troubles ___Marriage ___Use Alcohol ___Allergies

___Suicidal ___Sexual Problems ___Work ___Under eating

___Overeating ___Home Conditions ___Friends ___Concentration

___Temper ___Ambition ___Divorce ___My Thoughts

___Parenthood ___Health Problems ___Age ___Finances

___My appearance ___Future ___Sexual Abuse ___Children

___Career Choices ___Weight ___Unhappiness ___Depression

___Mood Swings ____Fears ___Self-esteem ___Physical Abuse

**Circle everything that has happened to you in the past two years:**

Death of a spouse/partner Marriage Problems Divorce

Death of a family member Family Issues (with children/parents/in-laws)

Major illness/injury of self Financial issues Move to another city or state

Major illness/injury of relative Legal Problems Bad break up

Job dissatisfaction Loss of job Other _____

**Religious/Spiritual/ Faith Information:**

How often do you attend Church, Synagogue, or other religious services? _____

If so, where do you attend?_____

Describe your religious/spiritual upbringing

_____

_____

Describe any specific religious/spiritual beliefs/values you feel strongly about _____

_____

**<u>Consent for evaluation and treatment</u>**. –

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: _____ Date:

In the case of a minor child, please specify the following:

Full name of minor:_____ DOB _____ Relationship: