Client Intake Form

Welcome to Epiphanye Counseling Services! I look forward to providing you with quality and effective services. Please provide the following information and answer the questions below. The information you provide will help me to understand your situation and help me best help you. Please note that the information you provide on this form is confidential. Please fill out form and complete prior to the session.

Today's Date: _____

Type of Services being sought (check all that apply):

□ Individual □ Couple/Marital □ Family □ Group

Referred by: _____

General Information:

Name (person filling out application):

_____

(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: Gender: □ Male □ Female

Marital Status:

Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

Cell/Other Phone: _____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

E-mail: _____ May we send you our newsletter? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication. ECS has secure email for those who would like to communicate through email.

Spouse/Significant Other:

Name: _____

(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: Gender: □ Male □ Female

Address (if different than above):

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: _____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

Cell/Other Phone: _____ May we leave a message? □Yes □ No
May we identify ourselves as ECS? □Yes □ No

E-mail: _____May we send you our newsletter? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication. ECS has secure email for those who would like to communicate through email.

Would you like appointment E-mail reminders? □Yes □ No

May we send material/information to your home? □ Yes □No

May we follow-up after discharge of services? □ Yes □No

Please provide a security question and answer to transmit sensitive information securely via email_____

Emergency Contact

Name: _____ Rel. to Client_____

Phone: _____

Name: _____ Rel. to Client_____

Phone: _____

Names of other individuals living in Household:

Last, First Name	Relation to Client	Age/Birth Date	Employment /Highest Grade Completed

What is your annual household income (for clients using sliding fee scale rate)? _____

What are your primary concerns?

1. _____
2. _____
3. _____

What are your goals for counseling?

1. _____
2. _____
3. _____

What is your primary language? _____

Race: _____

Cultural Considerations_____

Religion: _____

What special accommodations do you need (if applicable)? _____

_____

Mental Health and Social History

Has anyone in the family attended therapy previously or is currently in treatment (Psychotherapy, Psychologist, Psychiatric services.)? Yes □ No □ If yes, please explain:

Name	Reason for Treatment	Dates of treatment

Is/has anyone currently taking/taken any prescription medications? Yes □ No □ If yes, please list:

Name	Medication	Duration of Use

Is/has anyone currently taking/taken prescribed psychiatric medication? Yes □ No □ If yes, please list:

Name	Medication	Duration of Use

Is/Has anyone in the family having/ had suicidal/homicidal thoughts/attempts? Or engage (d) in self-injurious behaviors? Yes □ No □ if yes, please explain:

Name	Type of problem	Dates of treatment

Has anyone in the family been a victim or perpetrator of child/elder abuse (physical, sexual, emotional, neglect), domestic violence, rape or related violent behaviors? Yes □ No □ if yes, please explain:

Name Type of abuse/trauma Dates of treatment

_____

_____

_____

Has anyone in the family have or been involved with the legal system (probation, jail, prison, DUI etc.)? Yes □ No □ if yes, please explain:

Name Reason Dates of treatment

_____

_____

_____

Does/has anyone in the family have/ had trouble with alcohol or other substances? Yes □ No □ if yes, please explain:

Name Substance Used Frequency/Amount

_____

_____

_____

Medical History

Is or has anyone in the family being treated for a medical problem(s) and/or disability?

Name Condition Dates of treatment

_____

_____

_____

Personal Strengths, Interests and Relationships

What are your strengths (please list strengths as an unit)?

_____

_____

Please list your support system(s)?

_____

Is there anything else that you would like me to know? Please explain

_____

_____

Thank you for taking the time to complete this form!