Client Intake Form

Contact Information

Date: ___________________________ Referred By: ____

Name:___________________________ Date of Birth:____________________ Age:____________________________

SSN:____________________________ Form completed by (if someone other than client):_________________________

Cell Phone:_______________________ Home Phone:____

Home Address: ____

Mailing Address (if different than Home Address):____

May I contact you at your: ___ cell phone ___ home phone ___ work phone ___ mailing address

Emergency Contact Information:

Name:__________________________________ Relationship:____

Cell Phone:__________________________________ Home Phone: ____

Home Address:____

Education

Are you currently in school? YES / NO

Fill out the highest education completed:

____ high school ____vocational school ____College _____ Graduate School

Major/Degree Received:____

Military Experience: YES / NO Combat Experience: YES / NO

Branch:_________________________________Rank:____________________________

Work

Are you currently employed? YES / NO

Current Employer: ____

Length of employment:__________________________ Average Salary:_______________________________________

Are you happy with current work/school situation? If not, please briefly explain.

____

Religious Background

How important are spiritual matters to you?

____Not at All ____ A Little ____Moderate ____A Lot

Are you affiliated with a spiritual or religious group/church/synagogue? YES / NO If Yes, describe:

____

Were you raised within a spiritual or religious group/church/synagogue? YES / NO

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? YES / NO

If Yes, describe: ____

Relationship Information

Are you currently: __ married __ single __ divorced __ separated __ living with a partner __ widowed __ engaged

If married, how long? _______________ If living with a partner, how long? ________________________

How long have you known your spouse/partner: ____

Spouse's/Partner's Name:______________________________________ Age:_____________________

Spouse/Partner's Occupation:____

Race: ____ Black ____White ____Asian ____ Latino ____ Other

Gender: ____ male ____ female

Briefly describe your spouse/partner:____

Briefly describe the state of the marriage or partnership:____

If divorced, how long?________________# of Marriages: You:_____________Your Spouse/Partner: ______________

Family of Origin

Please list your parents/siblings/significant people.

Name	Age	Living or Deceased?	Brief Description

Children

Please list all your children (including stepchildren):

Name of Child	Biological, Step, or Adopted	Age	Currently lives with you?	Description of Child

Family/Childhood History

Are your parents legally married? YES / NO

Have your parents have ever been separated? YES / NO

Are your parents divorced? YES / NO

If so, how old were you when they divorced?________________

Is Mother remarried: YES / NO

Number of Marriages for Mom:___________________________

Is Father remarried: YES / NO

Number of Marraiges for Dad:___________________________

Special circumstances (e.g., raised by person other than parents, etc.)____

Are there special, odd, or traumatic circumstances that affected your development as a child? YES / NO

If Yes, please describe:____

Has there been history of child abuse? YES / NO

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition

Other (please specify):____

Medical History

Current Primary Physician:___________________Phone: _____________________Address:__________________________

Are you currently receiving medical treatment: YES / NO If Yes, please specify:______________________________

List any conditions, illnesses, surgeries, hospitalizations, traumas, or related treatments you've had (use back if necessary):____

How many pregnancies have you had? ________ How many live births have you had? ________

How many abortions? ________ How many miscarriages? ________ How many stillbirths? ________

Please list all medications you are taking:

Current Medication	How long been taking?	Prescribed for?	Is it working effectively?

Height: ______ Weight: ______ Weight increase/decrease in last 2-3 months? Yes/No

Physiological Symptoms

Please check any of the following physiological symptoms that apply to you presently or recently:

Symptom	Present	Past	Symptom	Present	Past
Headache			Sleep Trouble		
Blurry Vision			Tiredness		
Stress			Seeing Things		
Appetite Change			Anger Outbursts		
Difficulty Breathing			Crying Outbursts		
Hearing Voices			Pain		
Dizziness			Stomach Problems		

Are you currently experiencing any suicidal thoughts? YES / NO

Have you experienced them in the past? YES / NO Have you ever attempted suicide YES / NO

If so, when? ____________________ Have any of your friends or family attempted or committed suicide? YES/NO

If Yes, when and who? ____

Current Status

Circle all that apply

Stress	You	Family	Career Choices	You	Family
Guilt	You	Family	Recent Loss	You	Family
Recent Deaths	You	Family	Pornography	You	Family
Inferiority Feelings	You	Family	Nervousness	You	Family
Marriage Problems	You	Family	Unhappiness	You	Family
Emotional Abuse	You	Family	Apathy	You	Family
Temper	You	Family	Grief	You	Family
Self Control	You	Family	Defective Feelings	You	Family
Pregnancy	You	Family	Loneliness	You	Family
Trauma	You	Family	Friends	You	Family
Alcohol Use	You	Family	Physical Abuse	You	Family
Ambition	You	Family	Sexual Abuse	You	Family
Being a Parent	You	Family	Aggressiveness	You	Family
Sexual Trauma	You	Family	Racing Thoughts	You	Family
Nicotine Use	You	Family	Loss of Control	You	Family
Anxiety	You	Family	Compulsivity	You	Family
Depression	You	Family	Abortion	You	Family
Terminal Illness	You	Family	Eating Problems	You	Family
Hopelessness	You	Family	Trouble with Job	You	Family
Bad Dreams	You	Family	Making Decisions	You	Family
Unwanted Thoughts	You	Family	Fears	You	Family
Impulsive Behavior	You	Family	Communication	You	Family
Sexual Problems	You	Family	Verbal Abuse	You	Family
Legal Matter	You	Family	Anger	You	Family
Drug Use	You	Family	Concentration	You	Family
Finances	You	Family	Memory	You	Family
Shyness	You	Family	Head Trauma	You	Family

Counseling/Prior Treatment History

Prior Counseling/Psychiatric Treatment: YES / NO If yes, when and where?_______________________________

Prior Drug/Alcohol Treatment: YES / NO If yes, when and where?_______________________________

Hospitalizations: YES / NO If yes, when and where?_______________________________

Involvement with Self Help Groups (AA, Al-Anon, SA, etc): YES/NO

Presenting Issues and Goals

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1= Very Little Distress; 10=Extreme Distress)

____

1 2 3 4 5 6 7 8 9 10

Please describe why you are coming to counseling:____

What do you hope to gain or change by coming for counseling?____

________________________ ________________________ ________________________

Client Name (Print) Client Signature Date