CLIENT INTAKE

Client Name: _____

Date: _____

Gender: Male ____ Female___

SSN: _____

Driver's License: _____

Form completed by (if someone other than client): _____

Date of Birth: _____ Age: _____

Marital Status: (More than one answer may apply)

Single:

Legally Married Length of Time:

Widowed Length of Time:

Unmarried, Living Together Length of Time:

Divorced Length of Time:

Divorce in Process Length of Time:

Total Number of Marriages:

Separated Length of Time:

Annulment Length of Time:

Religious/Cultural/Ethnic:

To which cultural or ethnic group do you belong?

Are you experiencing any problems due to cultural or ethnic issues? If yes, describe:

Other cultural/ethnic information:Would you like your spiritual/religious beliefs incorporated into your counseling? Yes _____ No _____

Do you have a religious affiliation? Yes _____ No _____

Legal:

Are you involved in any criminal proceedings or litigation at the present time? Yes____ No_____
If yes, describe:

Are you presently on probation or parole? Yes____ No _____

If yes, describe:

Prior counseling and/or treatment history:

Counseling/Psychiatric Treatment and Date:

Suicidal Thoughts/ Attempts and Date:

Drug/Alcohol Treatment and Date:

Hospitalizations and Dates:

Involvements with Self- help Groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous):

Presenting Concerns (Please circle all that apply)

Anger Management	Eating Habits	Parenting
Anxiety	Eating Disorder	Relationship Family
Addictive Behaviors	Fear/Phobias	Sexual Concerns
Alcohol/Drugs	Job	Sleeping Problems
Coping	Marital Problems	
Depression	Mental Confusion	

Other Concerns:

Education:

Level of education completed:

High School ____GED ____ Some College _____Associate _____

Bachelors _____Master's _____Doctorate _____ Other _____

Special circumstances (e.g., learning disabilities, gifted):

Currently enrolled in school? Yes _____ No _____

If yes, where:

Military experience? Yes _____ No _____

Branch of Service:

Discharge Date:

Family Information Please indicate if living with you.

Parents:

Children: Please indicate if step/half children, adopted, and living with you:

Siblings:

Other significant family members: siblings, grandparents etc.

Deceased Family Members:

Positive Experiences:

Please describe what is going well presently:

What are some positive coping strategies for you?

Medical/Physical Health: (Please circle all that apply)

AIDS	Chronic Pain	Energy Level
Alcoholism	Dizziness	Fatigue
Abortion	Diabetes	General Disposition
Anemia	Drug AbuseEpilepsy	Hepatitis
Bladder Control	Eating Patterns	Headaches/Migraines
Cancer	Eating Problem	High Blood Pressure

Medical/Health Problem	Nervousness/Tension	Sleeping Disorders
Mononucleosis	Physical Activity Level	Stomach Aches
Miscarriages	Sleep Patterns	Weight
Nausea	Sexual Problems	Thyroid Problems
Neurological Disorders	Sexually Transmitted Diseases	Vomiting

Other (describe):

List any current health concerns:

List any recent health or physical changes:

Current Prescribed Medications and Dose:

Current Over-the-Counter Meds/Vitamins and Dose:

Describe changes in areas in which you circled above:

Have any of your family members or significant others had counseling or treatment in any of the above areas?

Do you drink alcohol? Yes _____ No _____

If yes, how often and in what quantity?

Have you used/abused drugs, alcohol or controlled substances?

Yes _____ No _____

If yes, please explain:

Does anyone in your family have/had a problem with drugs or alcohol?

Yes _____ No _____

If yes, please describe:

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes _____ No _____If yes, describe:

Have drugs or alcohol created a problem for your job/relationship? Yes, No

If yes please describe:

Behavioral History:

Please circle behaviors and symptoms that are problematic for you:

Aggression	Fears
Anger	Fatigue
Alcohol Dependence	Gambling
Anemia	Hallucinations
Anxiety	Hopelessness
Avoiding People Chest Pain	Hyperactivity
Cyber Addiction	Impulsivity
Depression	Irritability
Disorientation	Judgment Errors
Distractibility	Loneliness
Disorganized Thoughts	Memory Impairment
Dizziness	Mood Shifts
Disruptive Thoughts	Panic Attacks
Drug Dependence	Phobias
Drug Dependence	Pornography
Eating Disorder	Pressure

Sexual Addiction

Sexual Difficulties

Sleeping Problems

Social Problems

Speech Problems

Spending Problems

Other (Specify)

Spiritual changes/difficulties

Suicidal Thoughts

Trembling

Withdrawing

Worrying

Briefly discuss how the above symptoms impact your ability to function:

Does anyone in your family have a history of anxiety, depression, or other mental health problems? Yes _____No _____If yes, describe:

Stress Indicators:

Were there special, unusual, or traumatic circumstances that affected you in childhood? (i.e. – car accidents, domestic violence, violent trauma, abuse, natural disasters, significant loss)

Yes_____ No_____

Please check any events that have occurred in the last 12 months:

Birth of a Child

Death of a Close Family Member/Friend

Car Trouble

Divorce/Separation

Family Issues/Situations

Other:

Financial Problems

Job Change/Stress

Marriage

Moving

Natural Disaster

COUNSELING GOALS

What would you like to accomplish in your counseling?

1.

2.

3.

4.