Client Intake Form

Client Information Today's Date: _____/_____/_____ Time: _____

Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

City: _____ State: _____ Zip: _____ Email: _____

Date of Birth: ____/____/____ Age: _____ Social Security #: ☐☐☐-☐☐-☐☐☐☐

Gender: ☐ Male ☐ Female ☐ Transgendered

Relationship Status: ☐ Single ☐ Legally Married ☐ Domestic Partner
☐ Civil Union ☐ Divorced ☐ Separated

Level of Education: ☐ Grade (specify) _____ ☐ High school ☐ College
☐ Graduate school ☐ Ph.D., M.D.

Religious Affiliation: _____

Legal Guardian(s)

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Name: _____ Policy #: _____

Address: _____ Group#: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Employment/School Information Occupation: _____

Employer/School Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Phone number: _____

Referral Information

☐ Self ☐ Phonebook ☐ Print Media ☐ Other: _____

8/7/00

The following questions will help in planning how you might benefit most from counseling. Please try to answer all the questions.

Presenting Concern/Issue:

1. Briefly describe your reasons for seeking help now. _____

_____

_____

_____

2. How long have you been dealing with this issue(s)? _____

3. What makes it better? _____

_____

_____

4. How have you managed the issue until now? _____

_____

_____

5. Circle any of the following that have been a concern to you recently.

nervousness	depression	fear	low self-esteem
sexual concerns	anger	suicidal thoughts	divorce/separation
finances	trouble sleeping	trouble relaxing	low energy
legal issues	loneliness	few friends	heart racing
anxiety	headaches	panic attacks	relationship conflicts
health problems	racing thoughts	self-critical	lack of concentration
parenting difficulties	nightmares	indecision	change in appetite
job stressors	shyness	impulsiveness	avoid people or places

Previous Treatment:

1. Have you ever received psychotherapy services? ☐ Yes ☐ No If yes, please describe.

_____

_____

_____

2. What did you find most helpful? _____

_____

3. Least helpful? _____

_____

_____

Family History:

1. List members of your *family of origin* (grandparents, parents, and siblings) and their ages.

Name	Relationship	Approximate Age

2. List members *living in your present household* (names, sex, relationship, age, & occupation).

Name	Relationship	Approximate Age

3. What significant events have happened to you or your family this past year? _____

_____

_____

4. How would you describe your childhood? _____

_____

_____

5. History of abuse/neglect? _____

6. Any family history of substance abuse? _____

7. Any family history of legal issues? _____

8. Family history of psychiatric problems? _____

9. For clients under the age of 18, are there specific developmental issues that have occurred in your childhood (issues with birth, feeding, movement, health, learning, school, etc.)? (*please describe):*_____

_____

_____

_____

Medical History:

1. When was your most recent physical exam? _____

2. Primary Care Physician: _____
[Name] [Phone #]

3. Psychiatrist: _____
[Name] [Phone #]

4. Do you have any history of head injury? ☐ Yes ☐ No If yes, please explain briefly. _____

_____

_____

5. List any health problems for which you are currently receiving treatment. _____

_____

_____

6. Please list any drugs or medications that you are currently taking.

Name	Dosage	Frequency

7. Please list any hospitalizations and/or surgeries and approximate dates? _____

_____

_____

8. List any allergies (medications, environment, etc.)? _____

_____

Substance Use:

	Age of		Frequency of use at current/ heaviest period	Amount used at current/ heaviest period	Withdrawal symptoms	Usual route of administration
	First Use	Last Use				
Alcohol						
Amphetamines						
Cannabis						
Cocaine						
Hallucinogens						
Opiates						
Sedatives/ Hypnotics						
Tobacco						
Coffee/tea/soda						
Other:						

Legal History:

1. Please describe any legal history that you or your family has experienced. _____

_____

_____

Other Supports/Services:

1. Who are the people that you get the most support from? _____

_____

_____

2. Are you connected to any agencies or services? _____

_____

3. Do you think that you need any additional services? _____

_____

Educational/Employment History:

1. What is the highest grade you have completed? _____

2. How did you do or how are you doing in school? _____

_____

_____

3. Did you or are you receiving and specialized school services? _____

_____

4. Current Job? _____

5. Previous jobs? _____

_____

7. What is the longest job you have ever held? _____

Additional Information:

1. Briefly describe something that you feel you have been successful at doing? _____

_____

_____

2. What are your strengths? _____

_____

3. List any sports, hobbies, activities or interests that you have? _____

_____

_____