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**COUNSELING CLIENT INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [COUNSELOR’S NAME]. Information collected about new clients is confidential and will be treated accordingly.

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| **PATIENT DETAILS** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**:  Male  Female  Other

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Ethnicity/Race**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education**:  GED  High School  Bachelor’s  Master’s  Ph.D.

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| **RELIGION** |

**Do you currently practice a religion?**  Yes  No

-If yes, what is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **EMERGENCY CONTACT** |

**Emergency Contact Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **RELATIONSHIP STATUS** |

**Marital Status**:  Single  Married  Divorced  Widowed

**Length of Current Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assessment of Current Relationship**:  Poor  Fair  Good  Great

**Number of Marriages**: \_\_\_\_

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| **EMPLOYMENT** |

**Are you currently employed?**  Yes  No

**Employer’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pay**: $\_\_\_\_\_\_\_\_\_\_\_\_ per year (approx.)

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MILITARY HISTORY** |

**Military Experience?**  Yes  No **Combat Experience?**  Yes  No

**Branch**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Length of Service**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Discharge**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Rank**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HOUSEHOLD AND FAMILY** |

List your current immediate family:

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_

-Living with you?  Yes  No

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_

-Living with you?  Yes  No

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_

-Living with you?  Yes  No

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_

-Living with you?  Yes  No

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_

-Living with you?  Yes  No

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| **MEDICAL INFORMATION** |

**Primary Care Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

List any current **medical problems**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current **medications**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current **allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you taken medication for a mental health concern?**  Yes  No

Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Was it helpful?  Yes  No

Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Was it helpful?  Yes  No

Medication Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Was it helpful?  Yes  No

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| **MEDICAL INSURANCE** |

**Primary Insurance Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policyholder’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ID #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Type**:  HMO  PPO  Medicare  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PREVIOUS COUNSELING** |

**Have you previously seen a counselor?**  Yes  No

-If yes, who and where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate dates of counseling**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for counseling**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a previous mental health diagnosis?**  Yes  No

-If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you find **most helpful** in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you find **least helpful** in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you used psychiatric services before?**  Yes  No

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| **ALCOHOL & DRUG USE** |

**Do you currently consume alcohol?**  Yes  No

* How often?  Daily  Weekly  Occasionally  Rarely
* How many drinks? \_\_\_\_ drink(s)

**Do you currently smoke?**  Yes  No

* What do you smoke?  Tobacco  Marijuana  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you currently use any other drugs?**  Yes  No

* What other drugs do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How often?  Daily  Weekly  Occasionally  Rarely

**Have you ever received treatment for alcohol or drug use?**  Yes  No

* Where did you go? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Inpatient  Outpatient

**Have you ever felt the need to cut down on your drinking/drug use?**  Yes  No

**Have you ever had other people criticize your drinking or drug use?**  Yes  No

**Have you ever felt bad or guilty about drinking or drug use?**  Yes  No

**Have you ever had a drink or used drugs first thing in the morning?**  Yes  No

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| **CURRENT ISSUES** |

**What are the main issues for which you are seeking counseling?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When did these issues first start?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What results would you like to get from counseling?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the most concerning issue for you right now?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FAMILY CONCERNS** |

Please check ANY of the following family concerns you are experiencing:

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| - Abuse / neglect  - Arguing  - Alcohol use  - Birth of a family member  - Death of a family member  - Divorce / separation  - Drug use  - Education problems  - Financial problems  - Inadequate health insurance | - Inadequate housing / feeling unsafe  - Infidelity  - Feeling distant  - Job change  - Job dissatisfaction  - Loss of fun  - Lack of honesty  - Lack of intimacy  - Marriage issues  - Physical fighting |

List any other family concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PERSONAL CONCERNS** |

Please select the severity of EACH of the following concerns:

* **Alcohol use** -  None  Mild  Moderate  Severe
* **Anger issues** -  None  Mild  Moderate  Severe
* **Anorexia** -  None  Mild  Moderate  Severe
* **Anti-social behavior** -  None  Mild  Moderate  Severe
* **Anxiety / paranoia** -  None  Mild  Moderate  Severe
* **Appetite changes** -  None  Mild  Moderate  Severe
* **Bi-polar behavior** -  None  Mild  Moderate  Severe
* **Binging / purging** -  None  Mild  Moderate  Severe
* **Crying** -  None  Mild  Moderate  Severe
* **Decreased sex drive** -  None  Mild  Moderate  Severe
* **Drug use** -  None  Mild  Moderate  Severe
* **Excessive worrying** -  None  Mild  Moderate  Severe
* **Fear of death** -  None  Mild  Moderate  Severe
* **Headaches / migraines** -  None  Mild  Moderate  Severe
* **Hopelessness** -  None  Mild  Moderate  Severe
* **Hyperactivity** -  None  Mild  Moderate  Severe
* **Impulsivity** -  None  Mild  Moderate  Severe
* **Inability to focus** -  None  Mild  Moderate  Severe
* **Indecisiveness** -  None  Mild  Moderate  Severe
* **Low energy** -  None  Mild  Moderate  Severe
* **Low self-worth** -  None  Mild  Moderate  Severe
* **Nausea / indigestion** -  None  Mild  Moderate  Severe
* **Nightmares** -  None  Mild  Moderate  Severe
* **Panic attacks** -  None  Mild  Moderate  Severe
* **Poor concentration** -  None  Mild  Moderate  Severe
* **Problems at home** -  None  Mild  Moderate  Severe
* **Racing thoughts** -  None  Mild  Moderate  Severe
* **Restlessness** -  None  Mild  Moderate  Severe
* **Sadness** -  None  Mild  Moderate  Severe
* **Self-mutilation** -  None  Mild  Moderate  Severe
* **Sleep deprivation** -  None  Mild  Moderate  Severe
* **Spiritual concerns** -  None  Mild  Moderate  Severe
* **Suicidal thoughts** -  None  Mild  Moderate  Severe
* **Trauma flashbacks** -  None  Mild  Moderate  Severe
* **Unresolved guilt** -  None  Mild  Moderate  Severe
* **Weight (over or under)** -  None  Mild  Moderate  Severe
* **Work issues** -  None  Mild  Moderate  Severe
* **Workaholic (working too much)** -  None  Mild  Moderate  Severe

List any other concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SIGNATURE** |

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_