COUNSELING CLIENT INTAKE FORM

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

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.

RELIGION

Do you currently practice a religion? ☐ Yes ☐ No
-If yes, what is your faith? ______________________

EMERGENCY CONTACT

Emergency Contact Name: ______________________

Relationship: ______________________

E-Mail: ______________________ **Phone**: ______________________

RELATIONSHIP STATUS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Length of Current Relationship: ______________________

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

Number of Marriages: ____

EMPLOYMENT

Are you currently employed? ☐ Yes ☐ No

Employer's Name: ______________________ **Occupation**: ______________________

Pay: $_____________ per year (approx.)

Street Address: ____

City: ______________________ **State**: ______________________ **Zip Code**: ________

Phone: ______________________

MILITARY HISTORY

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

Branch: ______________________ **Length of Service**: ______________________

Type of Discharge: ______________________ **Rank**: ______________________

HOUSEHOLD AND FAMILY

List your current immediate family:

Name: ______________________ **Relationship**: ______________________ **Age**: ____
-Living with you? ☐ Yes ☐ No

Name: ______________________ **Relationship**: ______________________ **Age**: ____
-Living with you? ☐ Yes ☐ No

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Name: ______________________ **Relationship**: ______________________ **Age**: ____
-Living with you? ☐ Yes ☐ No

Name: ______________________ **Relationship**: ______________________ **Age**: ____
-Living with you? ☐ Yes ☐ No

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

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Medication Name: ______________________ Dates: ______________________
-Was it helpful? ☐ Yes ☐ No

MEDICAL INSURANCE

Primary Insurance Company: ______________________

Policy Holder's Name: ______________________ **Group #**: ______________________

ID #: _______________ **Type**: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _______________

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

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

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?

____

FAMILY CONCERNS

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

☐ - Abuse / neglect
☐ - Arguing
☐ - Alcohol abuse
☐ - Birth of a family member
☐ - Death of a family member
☐ - Divorce / separation
☐ - Drug abuse
☐ - 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: ____

PERSONAL CONCERNS

Please select the severity of EACH of the following concerns:

- **Alcohol abuse** - ☐ 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 abuse** - ☐ 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: ____

SIGNATURE

Signature: ________________________ Date: ________________________

Print Name: ________________________