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** CONFIDENTIAL Client Intake Form**

Please bring this form completed to your first appointment.

Name: Prefer to Be Called:_____ **Today's Date**:_____

Last_____ First_____ MI _____

Maiden/Other_____ Date of Birth_____ Age _____

Address & Phone:

Street_____ City/State_____ Zip code_____

Who lives there with you (& their relationships to you)?_____

Email Address _____

Permanent Mailing Address (if different from above):

Street_____ City/State_____ Zip code_____

Telephone #'s: Home_____Work_____ Cell_____

Which number(s) may I call & leave a message on *(circle)*? (Home) (Work) (Cell)

Emergency Contacts:

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Name_____ Phone #_____ Relationship_____

Demographics *(Circle all that apply, all are OPTIONAL.)*

Ethnic Group You Identify As
American Indian/Alaskan Native
Asian
Black/African-American
Native Hawaiian/Pacific Islands
White/Caucasian
Latina/Latino
Middle-Eastern
Multi-Ethnic
Other/Details: _____

Relationship Status
Single
Partnered
Separated
Widowed
Other_____

Do you have children? __No __Yes
If yes, how many, ages, where do they live?
_____

Religious/Spiritual Affiliation(s)
_____
_____

Gender
Female
Male
Transsexual/Transgender
Other_____
Preferred Gender Pronoun:_____

Sexual Orientation
Bisexual
Gay/Lesbian
Heterosexual
Uncertain
Queer

Current Employment Status
Employed – Full Time
Employed – Part Time
Not in Labor Force
Student – Full Time
Student – Part Time

What are the (some of the) reasons you are seeking support *(Primary Concerns)*?

_____

_____

_____

What have you already tried to effect change/ manage the problem or concern?

_____

_____

What are your strengths? *(talents, hobbies, education, personality, habits, passions, relationships, skills)*

_____

_____

_____

Describe aspects *(if any)* that you want to change? What is/are your goal(s) for counseling?

_____

_____

How do think counseling will help you make these changes/reach your goal(s)?

_____

_____

How long do you think/imagine this process will take? _____

Have you ever been in counseling before? __No __Yes Please describe your experience:_____

_____

_____

What qualities do you think a counselor should have to support your current goals?

_____

_____

Please list all medications/drugs/supplements you currently use *(prescribed and non-prescribed)*:

Name of Medication/Herbs	Dosage	Used to Treat	Prescribed by

Please list any current medical problems/concerns: _____

_____

Please describe your current alcohol use and frequency: _____

_____

Please describe your current drug/substance use and frequency: _____

_____

Have you ever experienced abuse?

Physical	__ No __Yes
Sexual	__ No __Yes
Emotional	__ No __Yes
Other	__ No __Yes

Feel free to share any details you wish about these or other trauma, abuse, losses and/or difficult transitions you have experienced: _____

_____

_____

Family History

Briefly, describe your family of origin: _____
_____
_____
_____

What was it like growing up in your family? _____
_____
_____
_____

List any psychiatric *(anxiety, depression, bipolar, schizophrenia, substance abuse, etc.)* or medical illnesses that you/your family/relatives have experienced.

_____
_____
_____

(if known) Birth History

Parent's age at time of your birth: *Mother* _____ *Father* _____

Was this a planned pregnancy? *Yes* *No* *Don't Know*

Any tobacco, drug or alcohol use during pregnancy? *Yes* *No* *Don't Know*

Any complications during pregnancy, labor or delivery? *Yes* *No* *Don't Know*

Did your mother experience postpartum depression following birth? *Yes* *No* *Don't Know*

Anything else you know/want to share of your birth history …

Medical History

Allergies?_____ Past prescribed medications _____

Childhood illnesses/surgeries? _____

Previous hospitalizations? _____

Anything else

What questions or concerns do you have?

_____
_____

Anything else you would like me to know in working together? _____
_____
_____
_____

Referred by: _____

I sometimes thank referrals in a way that is general, non-identifying. Would that be okay with you? (yes) or (no, thanks)

OFFICE USE ONLY …. INITIALS: DATE:

SYMPTOM CONCERNS:

Please circle appropriate responses – Feel free to write in other responses

*Star appropriate responses (*) that you would like to address in counseling*

Sleep: No problems Not enough Trouble getting to sleep Nightmares
Too much sleep Trouble getting up Tired upon waking up

Appetite: No problems Decreased Increased

Exercise: None Infrequently Often Frequency: _____ x per month / week

Energy: Normal Increased Low Up and down

Interest in sex: Normal Increased Low

Concentration: Normal Difficult Poor Terrible

Memory: Good Some difficulty Poor

Mood (Generally):

Thoughts: racing worries fears repetitive invincible detached paranoid

Reaction to Touch, Sounds, Lights, Tastes, Smells

Depressed or sad: All the time Most days Some days Not at all

Social (friends, support):

Suicidal thoughts: All the time Most days Some days Not at all

Past suicidal attempts: No Yes

Anxiety: Panic attacks All the time Most days Some days Not at all

Anger / Irritation: All the time Most days Some days Not at all

Are you religious or spiritual? O No O Yes; If yes, please give details:

Have you ever suffered from any type of eating disorder? O Yes O No

Have you ever been charged with a crime, arrested or convicted? O Yes O No

Have you ever struggled with substance use/abuse? O Yes O No

Do you have any work-related problems or difficulties in school? O Yes O No

Do you have a history of trauma *(i.e. abuse, neglect, natural or other disaster)***?** O Yes O No

On a scale of 0-10, how important is therapy to you right now? *(0-not important; 10-very important)***?** _____