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CONFIDENTIAL CLIENT INTAKE FORM

Please fill out as much information as you are willing to provide. Use the back of the form if you feel you need more room or to add anything about yourself that you want me to know, which I have not asked for.

Full Name: _____ Name you prefer: _____

Social Security Number: _____Age: _____ Date of Birth _____

Race: _____ Gender: _____Sexual Orientation: _____

Contact Information

Street Address: _____ Unit#: _____

City: _____ State: _____ Zip Code: _____ May I send mail here? Yes No

Email Address: _____ May I send a message here? Yes No

Home Phone: (____) _____ May I leave a message here? Yes No

Cell Phone: (____) _____ May I leave a message here? Yes No

Work Phone: (____) _____ May I leave a message here? Yes No

Emergency Contact:

Education/Employment Information

Last year of School Completed: 9 10 11 12 GED AA BA/BS Grad Post-Grad

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Relational Information

Current Marital Status: Single Partnered Married Separated Divorced Widowed

If Partnered/Married, How Long: _____ If Separated or Divorced, How Long: _____

With Whom Do You Currently Live? (Check all that apply):

__Alone ___Spouse/Partner(s) ___Children (#____) ___Parent(s) ____Siblings

Sexual Orientation: _____

Occupation: _____ # of hours worked per week: _____

Last year of School Completed: 9 10 11 12 GED AA BA/BS Grad Post-Grad

How would you describe this person? _____

Children

List your children (Living or Deceased) as well as children you have placed for adoption:

Name Current Age Relationship (natural/step/adopted) Living with you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever had a miscarriage or medical abortion? Yes No If yes, when: _____

Family of Origin
Please list family members in the family or families you grew up in. Please describe your relationship with them in general.
Examples (Good, Close, Strained, Cut-off, Difficult, Closest, Etc.)

Name	Gender	Age	Relationship to You	Description

Presenting Issue(s)

Please tell me why you are seeking counseling:

_____

_____

_____

_____

How long have these concerns been causing you distress? _____

Please check the boxes if you have had significant problems or concerns with any of the following, and circle the relevant time frame (Present = Recent Months):

Aggressiveness	Past Present	Loneliness	Past Present
Alcohol Abuse	Past Present	Loss of Control	Past Present
Anger	Past Present	Making Decisions	Past Present
Anxiety	Past Present	Memory	Past Present
Apathy	Past Present	Nervousness	Past Present
Nightmares	Past Present	Pain	Past Present
Change in Appetite	Past Present	Panic	Past Present
Compulsivity	Past Present	Physical Abuse	Past Present
Depression	Past Present	Racing Thoughts	Past Present
Difficulty Breathing	Past Present	Rapid Heart Rate	Past Present
Digestive Upset	Past Present	Serious Illness	Past Present
Dizzyness	Past Present	Sexual Abuse	Past Present
Eating Problems	Past Present	Sleep Difficulty	Past Present
Emotional Problems	Past Present	Social Anxiety	Past Present
Emotional Abuse	Past Present	Stress	Past Present
Fatigue	Past Present	Trauma	Past Present
Fears	Past Present	Trouble Focusing	Past Present
Finances	Past Present	Trouble Relaxing	Past Present
Grief/Loss	Past Present	Unhappiness	Past Present
Guilt	Past Present	Unwanted Thoughts	Past Present
Hearing Noises/Voices	Past Present	Verbal Abuse	Past Present
Impulsive Behavior	Past Present	Weakness	Past Present
Legal Matters	Past Present	Work Problems	Past Present

Are you currently experiencing any suicidal thoughts? Yes No

Have you experienced suicidal thoughts in the past? Yes No

Have you ever attempted suicide? Yes No

If yes, when and where: _____

Have you had any psychiatric hospitalizations? Yes No

If Yes, when and where: _____

Have any of your friends or family ever attempted or committed suicide? Yes No

If yes, when and who: _____

Medical Information

Primary Care Physician: _____Phone: (____)_____

Address: _____ City: _____Zip: _____

Are you currently receiving medical treatment? Yes No

If yes, please specify: _____

List any previous medical conditions including illnesses, surgeries, hospitalizations, or injuries you've had: _____

_____

_____

_____

Current Medication(s)	**Dosage**	**Taking For**

Emergency Contact: Name: _____ Phone: _____

Do you have a personal support system (Friends, Relatives, Meeting Groups)? Yes No

If Yes, Who: _____

Do you regularly attend a place of spiritual or religious worship? Yes No

If Yes, Where: _____

How important are spiritual matters to you? Not at all Somewhat Very Important

Would you like your spiritual/religious beliefs to be included in your counseling? Yes No

Other Information

What is your current living situation (Living alone, with parents, roommates, partner, spouse, children, pets, etc.)? _____

_____

What prior experience do you have with counseling or psychotherapy? What has been helpful or unhelpful in the past? _____

_____

_____

Please comment on any significant life experiences you have had that have had a significant effecct on making you the person you are today (these could be positive, or difficult and traumatic experiences):

_____

_____

_____

_____

What other information would be of value to me towards helping you? _____

_____

What specifically would you like to accomplish through working with me? _____

_____

_____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge. I understand that my personal information will be kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Signature: _____Date: _____