Client Intake Packet

Date: ____/____/____

Client Name: _____ Birth Date: ____/____/____ Age: _____

Male / Female (circle one)

Address: _____ _____

Home Phone: _____ Msg. OK? YES/NO

Work Phone: _____ Msg. OK? YES/NO

Cell Phone: _____ Msg. OK? YES/NO

Email: _____

Occupation: _____ Employer: _____

If applicable, please provide the name and age of your spouse/partner:

_____ Phone: _____

If applicable, please list the names and ages of your children:

_____

Describe your primary reason for seeking therapy at this time and what you hope to achieve:

_____

_____

Referred by: _____

Emergency Contact: _____ Phone: _____ I authorize Vanessa Little LPC intern to contact my emergency contact person in the event of an emergency.

Signature: _____ Date: _____

Health Information:

Are you currently taking medications for psychiatric or emotional problems? If so, please provide contact information for your prescriber:
Prescriber: _____ Date of last visit: _____
Address: _____
Phone: _____ Fax _____

Physician (if different then your prescriber):_____Address: _____Phone: _____

Please list any previous mental health diagnosis or general medical illnesses that you have had:

_____

Please list any prescriptions or over the counter medicines that you take regularly.

Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____

Please list any allergies that you have to foods, medicines or other things.

_____

Alcohol and Substance Use:

Do you currently consume alcohol? ____Yes ____No
If yes, on average how many drinks per occasion do you consume? _____
How many days per week? _____
What is the maximum number of drinks consumed during one occasion in the past year? _____
Do you have a history of problematic use of alcohol? ____Yes ____No
Have family members or friends expressed concern about your drinking? ____Yes ____No

Do you currently think you have a problem with illicit/prescription/non-prescription drug use?
____Yes ____No
If yes, please describe: _____

Do you have a history of problematic illicit/prescription/non-prescription drug use?
____Yes ____No
If yes, please describe:

_____

A family history of alcohol or drug problems? ____Yes ____No
If yes, please describe:

_____

Current Health and Wellness:

Are you having difficulty with appetite or eating habits? ____Yes ____No
If yes, please describe:

_____

Have you experienced significant weight change in the last 2 months? ____Yes ____No
If yes, please describe:

_____

Would you consider yourself as stressed? What types of stress would you describe as having and how does this affect you?

_____

Are you having any problems with your sleep? ____Yes ____No
If yes, please describe:

Are you currently self-harming in any way? YES / NO
Do you have a history of self-harming behaviors?

_____

Have you had suicidal thoughts recently? ____Frequently ____Sometimes ____Rarely ____Never
Have you had them in the past? ____Frequently ____Sometimes ____Rarely ____Never

Any previous therapy received? _____ Describe length and experience:

_____

Please describe your current support system:

_____

PROBLEM CHECK LIST (Past and/or Present) (Check all that apply)

- ☐ Making Friends
- ☐ Forgetfulness
- ☐ Understanding Others
- ☐ Shyness
- ☐ Feeling Victimized
- ☐ Lack of Goals
- ☐ Feeling Rejected
- ☐ Communication Problems
- ☐ Unable to Have a Good Time

- [ ] Unable to Cope with Day to Day Life
- [ ] Feel Cut off from Others
- [ ] Sexual Problem
- [ ] Affairs (emotional, sexual)
- [ ] Financial Problem
- [ ] Relationship struggles
- [ ] Fears/Phobias
- [ ] Excessive (racing) Thoughts
- [ ] Feel Depressed
- [ ] Feel Inferior
- [ ] Emotionally Numb
- [ ] Excessive Worrying
- [ ] Lack of Confidence
- [ ] Can't Make Decisions
- [ ] Experienced recent death of a loved one
- [ ] Suicidal Thoughts
- [ ] Complicated or unresolved grief from past loss
- [ ] Afraid of Being on My Own
- [ ] Feeling Anxious
- [ ] Feeling Tense
- [ ] Irregular Eating
- [ ] Physical Problem
- [ ] Sleep Problem
- [ ] Feeling Angry
- [ ] Performance at Work
- [ ] Physical Violence towards Others
- [ ] Can't Sit Still
- [ ] Self-Harm Behaviors
- [ ] Perfectionistic
- [ ] Unable to Relax
- [ ] Flashbacks
- [ ] Nightmares
- [ ] Seeing or Hearing Things
- [ ] Experience of loss of consciousness at any time
- [ ] Trauma (Psychological/Physical)
- [ ] Frequent Headaches
- [ ] Memory Loss
- [ ] Chronic Pain

- Other:

Additional Comments/Concerns or Questions for your Therapist:

_____

Printed Name: _____

Signature of Client: _____Date: _____

Thank You!