HOPE
COUNSELING CENTER
Building Strong Families. Enriching Lives.

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Today's Date: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phones: (W) _____ (H) _____ (C) _____

Any number you do not want to be contacted at: _____

Email: _____

Check here if you want Christian counseling ☐

Do you regularly attend a church, synagogue, or other religious institution? ☐ Yes ☐ No

If yes, which one? _____

RELATIONAL INFORMATION

Current marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If engaged, married, separated, divorced, or widowed, for how long? _____

Number of previous marriages for you: _____ For your spouse: _____

If married, spouse's name: _____ Age: _____

Is your spouse supportive of you seeking counseling? ☐ Yes ☐ No ☐ Unsure ☐ Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive):

_____

What is your current occupation? _____

What is your level of satisfaction with your occupation?

_____

Please list your children (including step, adopted, foster) below:				
Name	Sex	Age or yr. of death	Relationship to you	Living with whom?

Who else lives with you? _____

Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

Name	Sex	Age or yr. of death	Relationship to you	Describe him/her (e.g. angry, outgoing, supportive, controlling)

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back of this sheet if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?

☐ Yes ☐ No

If yes, please describe: _____

Have any of your family members or friends ever attempted or committed suicide?

☐ Yes ☐ No

If yes, who and when: _____

MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:

_____

Are you currently receiving any medical treatment? ☐ Yes ☐ No If yes, please describe: _____

Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)		
Name of medications	Dose	Reason for taking

Are you taking these medications according to the doctor's recommendations?

☐ Yes ☐ No

If no, please explain: _____

Date and outcome of last physical exam: _____

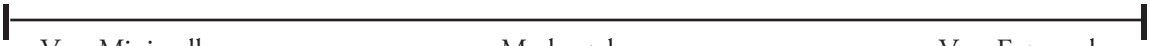
PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.): _____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3
☐ Stress	☐ Marital Problems	☐ Compulsive Behaviors
☐ Anxiety	☐ Other Relational Problems	☐ Seeing Things Others Don't
☐ Panic	☐ Physical Abuse	☐ Hearing Voices
☐ Depression	☐ Emotional Abuse	☐ Racing Thoughts
☐ Apathy	☐ Verbal Abuse	☐ Eating Problems
☐ Fatigue/Lack of Energy	☐ Sexual Abuse	☐ Drug Use
☐ Loss of Appetite/Overeating	☐ Sexual Problems	☐ Alcohol Use
☐ Trouble Sleeping	☐ Gender Identity Issues	☐ Pregnancy
☐ Poor Concentration	☐ Anger	☐ Abortion
☐ Feeling Worthless	☐ Aggressive Behavior	☐ Legal Matters
☐ Recent Death	☐ Bad Dreams	☐ Work Stress
☐ Grief	☐ Unwanted Memories	☐ Career Choices
☐ Chronic Pain	☐ Loss of Control	☐ Indecisiveness
☐ Loneliness	☐ Impulsive Behavior	☐ Parenting Problems
☐ Fears	☐ Controlling	☐ Financial Problems
☐ Shyness	☐ Controlled by Others	☐ Spiritual Problems
☐ Low Self-Esteem	☐ Obsessive Thoughts	☐ Other _____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.



Very Minimally Distressing — Moderately Distressing — Very Extremely Distressing

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No
Have you experienced suicidal thoughts in the past? ☐ Yes ☐ No
Have you attempted suicide in the past? ☐ Yes ☐ No
Are you currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

What do you hope to gain from this counseling experience? _____

_____ _____

Client's Signature Date