

CLIENT INFORMATION INTAKE FORM

THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL

(PLEASE PRINT CLEARLY)

Today's Date: _____

Name: _____ Birthdate _____ Age _____

Address _____

Street _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Can we leave a message? Yes No Best Place to Leave a Message (____) _____

Who were you referred by? _____

Level of Education: HS ___ College ___ Other ___ Place/Type of Employment _____

How long? _____ If unemployed, how long: _____ what type of work did you do? _____

Marital Status (Parents if for a child) married ___ # of years ___; divorced ___ # of years ___;

widowed ___ # of years ___; single ___; living with _____

Spouse's Name _____ Spouse's Occupation _____

CHILDREN (SIBLINGS IF FOR A TEEN)

NAME	BIRTHDATE	GENDER

In Case of Emergency Notify: _____ **Phone:** _____

Relationship: _____

Have you ever been hospitalized for psychiatric reasons? Y N If yes, what were the circumstances? Please include dates: _____

When was your last full physical exam? _____

Any physical issues? _____

Sleeping issues? Y N How many hours of sleep to you get each evening? _____

List any medications you are presently taking and dosage: _____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc)

Any problems with Alcohol? _____ drugs? _____

Do you have current thoughts of suicide? Yes No If so, do you have a plan? Yes No

Have you ever had thoughts about suicide Yes No

Have you ever attempted suicide? Yes No If yes, how many times? _____

How do you spend time relaxing? _____

Have you ever had concern about eating habits? Yes No

Reasons for seeking counseling at this time? _____

Have you ever been in counseling before? Y N For how long? _____

Was it helpful? Y N Please explain: _____

Is this your choice for counseling? (if no, please explain) _____

Please Check Any of the Following Conditions That Currently Apply to You

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Stomach Trouble | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Self Control |
| <input type="checkbox"/> No Appetite | <input type="checkbox"/> Anger | <input type="checkbox"/> Memory | <input type="checkbox"/> Making Decisions |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Separation | <input type="checkbox"/> Energy |
| <input type="checkbox"/> Inferiority | <input type="checkbox"/> Take Sedatives | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Bowel Troubles | <input type="checkbox"/> Marriage | <input type="checkbox"/> Use Alcohol | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Work | <input type="checkbox"/> Under eating |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Home Conditions | <input type="checkbox"/> Friends | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Temper | <input type="checkbox"/> Ambition | <input type="checkbox"/> Divorce | <input type="checkbox"/> My Thoughts |
| <input type="checkbox"/> Parenthood | <input type="checkbox"/> Health Problems | <input type="checkbox"/> Age | <input type="checkbox"/> Finances |
| <input type="checkbox"/> My appearance | <input type="checkbox"/> Future | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Children |
| <input type="checkbox"/> Career Choices | <input type="checkbox"/> Weight | <input type="checkbox"/> Unhappiness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Fears | <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Physical Abuse |

Circle everything that has happened to you in the past two years:

Death of a spouse/partner	Marriage Problems	Divorce
Death of a family member	Family Issues (with children/parents/in-laws)	
Major illness/injury of self	Financial issues	Move to another city or state
Major illness/injury of relative	Legal Problems	Bad break up
Job dissatisfaction	Loss of job	Other _____

Religious/Spiritual/ Faith Information:

How often do you attend Church, Synagogue or other religious services? _____

If so, where do you attend? _____

What is your perception of God? _____

Describe briefly your relationship with God _____

Are you involved in any Cults or the Occult Y N if yes, please explain:

Describe your religious/spiritual upbringing

Describe any specific religious/spiritual beliefs/values you feel strongly about _____

Consent for evaluation and treatment. –

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: _____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor : _____ DOB _____ Relationship: _____