

# CLIENT INTAKE FORM



Please answer the following questions to the best of your abilities. These questions are to help the counselor with the treatment process. This information is held to the same standards of confidentiality as our counseling.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor): \_\_\_\_\_  
(Last) (First) (Middle Initial)

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

Current address: \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_ Cell/other: \_\_\_\_\_

Email: \_\_\_\_\_

Referred by: \_\_\_\_\_

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change: \_\_\_\_\_

Have you had any mental health services in the past? Yes No

Reason for change: \_\_\_\_\_

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list: \_\_\_\_\_

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list: \_\_\_\_\_

**General Health and Mental Health Information**

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you on any medication for physical/medical issues? Yes No  
If yes, please list: \_\_\_\_\_

Are you having any problems with your sleep habits? Yes No  
If yes, circle those that apply:

Sleep too much Sleep too little Poor quality Disturbing dreams Other: \_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_ days \_\_\_\_\_ minutes/hours

Are there any changes or difficulties with your eating habits? Yes No  
If yes, circle one:

Eating less Eating more Bingeing Restricting

Have you experienced a weight change in the last two months? Yes No

Do you consume alcohol regularly? Yes No  
In one month, how many times do you have four or more drinks in a 24-hour period? \_\_\_\_\_

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Have you felt depressed recently? Yes No  
If yes, for how long? \_\_\_\_\_

Have you had any suicidal thoughts recently? Yes No  
If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No  
If yes, how long ago? \_\_\_\_\_

How often did you have these thoughts? Frequently Sometimes Rarely

Are you currently in a romantic relationship? Yes No

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? \_\_\_\_\_

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

### Quick Check

Circle the issues below that apply to you.

Extreme depressed mood	Mood swings	Rapid speech	Extreme anxiety
Panic attacks	Phobias	Sleep disturbance	Hallucinations
Memory lapse	Alcohol/substance abuse	Body complaints	Eating disorder
Repetitive thoughts	Anxiety	Time loss	Repetitive behaviors
Homicidal thoughts	Suicide attempts	Trouble planning	Difficulty with relationships

### Occupational Information

Are you currently employed? Yes No

If yes, who is your employer? \_\_\_\_\_

What is your position? \_\_\_\_\_

Are you happy in your current position? Yes No

Are you fulfilled in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors? \_\_\_\_\_

### Religious/Spiritual Information

Do you practice a religion? Yes No

If no, do you consider yourself to be spiritual? Yes No

### Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member.

Depression	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

**Other Information**

List your strengths \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List areas you feel you need to develop \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What do you like most about yourself? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are some ways you cope with life obstacles and stress? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Why are you seeking our help at this time? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_