Client Intake

Date:
Patient Name:
Social Security Number:
Date of Birth:
Gender: [ ] Male [ ] Female
Ethnicity:
Home Address:
Home Phone Number: May we leave a message? [ ] Yes [No
Work Phone Number: May we leave a message? [ ] Yes [ ]No
Mobile Phone Number: May we leave a message? [ ] Yes [ ]No
Employer:
Occupation:
Income:
Email:

If the above patient is a minor complete the following:
Name of Guardian:
Address of Guardian:
Guardian's Home Phone: May we leave a message? [ ] Yes [No
Guardian's Work Phone: May we leave a message? [ ] Yes [No
Guardian's Mobile Phone: May we leave a message? [ ] Yes [No
Who referred you to our office, or how did your learn about our practice?
Emergency Contact Information
In case of an emergency, who should we contact?
Name:
Relationship:
Address:
Phone Number:

History Information

Who is providing the history information?
[ ] The patient
[ ] The patient's guardian
[ ] Other
Please describe the current complaint or problem as specifically as you can, in your own words.
How long have you experienced this problem, or when did you first notice it?
What stressors may have contributed to the current complaint or problem?

Check all words/phrases that describe what you are experiencing and explain if possible.

[ ] Substance abuse/dependence
[ ] Addiction (internet, porn, shopping, exercise, gaming, gambling, etc.
[ ] Depression/Sad/Down feelings
[ ] High/Low energy level
[ ] Angry/Irritable
[ ] Loss of interest in activities
[ ] Difficulty enjoying things
[ ] Crying spells
[ ] Decreased motivation
[ ] Withdrawing from people/Isolation
[ ] Mood Swings
[ ] Black and white thinking/All or nothing thinking
[ ] Negative thinking
[ ] Change in weight or appetite
[ ] Change in sleeping pattern
[ ] Suicidal thoughts or plans/Thoughts of hurting yourself
[ ] Self-harm/Cutting/Burning yourself
[ ] Homicidal thoughts or plans/Thoughts of hurting others
[ ] Poor concentration/Difficulty focusing
[ ] Feelings of hopelessness/Worthlessness
[ ] Feelings of shame or guilt
[ ] Feelings of inadequacy/Low self-esteem
[ ] Anxious/Nervous/Tense feelings
[ ] Panic attacks
[ ] Racing or scrambled thoughts
[ ] Bad or unwanted thoughts
[ ] Flashbacks/Nightmares
[ ] Muscle tensions, aches, etc.
[ ] Hearing voices/Seeing things not there
[ ] Thoughts of running away
[ ] Paranoid thoughts/Thoughts that someone is watching you, out to get you or hurt you
[ ] Feelings of frustration
[ ] Feelings of being cheated
[ ] Perfectionism
[ ] Rituals of counting things, washing hands, checking locks, doors, stove, etc./ Overly concerned about germs
[ ] Distorted body image (believe you are heavier or less attractive than others say you are)
[ ] Concerns about dieting
[ ] Feelings of loss of control over eating

[ ] Binge eating/Purging
[ ] Rules about eating/Compensating for eating
[ ] Excessive exercise
[ ] Indecisiveness about career
[ ] Job problems
[ ] Other:

Previous Treatment

Have you received or participated in previous counseling and/or therapy?
[ ] Yes [ ] No
Have you had hospital stays for psychological concerns?
[ ] Yes [ ] No
Additional Information:
Are you currently experiencing thoughts of harming either yourself or someone else?
[ ] Yes [ ] No
Have you in the past experienced thoughts of harming either yourself or someone else?
[ ] Yes [ ] No
Are you satisfied at where you are in your life?
If not, where would you like to be?

Medical History

List any current or important past medications
Medication & Dose: Response to Medication:
History of serious childhood illnesses:
Other health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time:
Have you experienced any head injuries?
[ ] Yes [ ] No
Important Details:
If yes, did you lose consciousness?
[ ] Yes [ ] No
Have you experienced convulsions or seizures?
[ ] Yes [ ] No If yes, did you also have a fever? [ ] Yes [ ] No
Explain any allergies you have:
How would you rate your current physical health?
[ ] Excellent
[ ] Very Good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Very Poor
[ ] Yes [ ] No

Substance Abuse History

Are you currently or have you ever struggled with substance abuse? (alcohol, tobacco, marijuana, caffeine, or other)
[ ] Yes
[ ] No
If you answered yes, please describe abuse history.

Do you currently have any pending criminal charges?
[ ] Yes [ ] No
Are you on probation?
[ ] Yes [ ] No

If you answered yes, please describe below:

Additional Information
Summarize your goals for counseling/therapy:

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible?

How did you hear about my services?

_____ _____
Signature of client or guardian Date