INTAKE INFORMATION

ADULTS

Date

Client Name _____

Address _____

Home _____ Cell _____ Work _____

Date of Birth _____ Email _____

Occupation _____ Employer _____

Spouse/Partner _____ ☐ Married ☐ Not Married

Home _____ Cell _____ Work _____

Date of Birth _____ Email _____

Occupation _____ Employer _____

Who should we contact in case of emergency?

Name _____ Phone number _____

Referral Source _____ May we contact? ☐ YES ☐ NO

Immediate Family (children/step-children/parents/siblings)

Name	Relationship	Birthday	Education/Occupation	in home?
				☐
				☐
				☐

Services you are seeking: ☐ Individual Counseling ☐ Family Counseling ☐ Marital Counseling

Reason for seeking counseling:

_____

_____

_____

PLEASE COMPLETE BACK PAGE]

Health Information:

Doctor _____ Phone _____

Address _____

Current medical problems _____

Are they being treated? ☐ Yes ☐ No

Current medications taken _____

Have you seen a counselor, psychologist or psychiatrist before? ☐ Yes ☐ No

If yes, who, when and why? _____

_____

Please rate these symptoms you have observed in your child using the following scale:

0 = Never

1 = Little of the time

2 = Some of the time

3 = Good part of the time

4 = Most or all of the time

Please record your rating in the space at the left of each item.

Nervous and anxious _____

Upset easily or feel panicky _____

Headache, neck and backache _____

Digestive problems _____

Dizzy spells _____

Crying spells or feel like it _____

Sleep disturbance _____

Losing or gaining weight (not on diet) _____

Restless and can't keep still _____

Feel others would be better off if he/she were dead _____

Please check the following items as they pertain to you:

Chemical Use History

	Yes	No
Do you use drugs?	☐	☐
Do you alcohol?	☐	☐
Do you sometimes drink more than you had planned?	☐	☐
Have family/friends ever expressed concern about your use of alcohol?	☐	☐
Have you ever been arrested for alcohol related charges?	☐	☐
Have you ever had episodes where you were unable to remember periods when you were drinking?	☐	☐
Have family/friends ever expressed concern over your use of drugs?	☐	☐
Have you ever been arrested for any offense involving drugs?	☐	☐
Have you ever been treated for drug abuse?	☐	☐
Have you ever overdosed on drugs accidentally or purposely?	☐	☐
Has any member of your family had Problems with drugs or alcohol?	☐	☐
Do you use nicotine?	☐	☐

Risk Factors

	Yes	No
Do you know anyone who has ever attempted suicide?	☐	☐
Have you in the last year ever considered suicide?	☐	☐
Have you ever attempted suicide?	☐	☐
Have your personal problems affected your job performance in any way?	☐	☐

If yes, how? _____

_____

Have you ever been exposed to serious trauma?	☐	☐

If yes, how? _____

_____

Have you ever been sexually abused?	☐	☐
Have you ever been asked or forced to engage in touching, sexual activity against your will?	☐	☐

Legal History

Presently, are you involved in any legal problems?	☐	☐
Have you had legal problems in the past?	☐	☐

If yes to either question, please explain _____

_____