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CONFIDENTIAL CLIENT INTAKE FORM

Name: ______________________________ Date of Birth: ________________

Address:____

City: ____________________ State: ______________ Zip: ________________

Home Phone: __________________ Work/Cell Phone:____________________

E-mail: ____

May I leave a message and contact you by email? ______________________

Occupation/Work History: ____

Emergency Contact and Number: _____________________________________

Family Information

Marital Status: Single Engaged Living Together Remarried Widowed

Spouse/Partner Name(s):

____

Names and ages of children:

____

Are your parents living? ____

Number of siblings:____

Do any of your relatives have a history of mental illness? __ Yes __ No

If yes, please explain:____

____

____

Counseling Goals

Reasons for seeking help at this time:

____
____
____

How have these concerns evolved over time? _________________________
____
____

What are your goals for our counseling work?_________________________
____
____

Health History

Please indicate your major stressors over the last 12 months:

____
____

Have you ever received psychological or psychiatric counseling before?
___ Yes ___ No When? From Whom? Purpose? Results?

____
____

Are you currently taking or have you ever been prescribed any medications, herbs or supplements for depression or any other mental health condition?
__ Yes __ No When? Prescribing Clinician? What medication? Results?

____
____

Have you ever been hospitalized for a psychiatric reason? __ Yes __ No
When? Where? For What Reason? Outcome?

____
____

Have you ever been in a drug, alcohol or other treatment program?

__ Yes __ No When? Where? For What Reason? Outcome?

____
____

Do you currently drink alcohol? __ Yes __ No How much/how often:

____

Do you currently use recreational drugs? __ Yes __ No

How much/how often: ____

Do you feel you have a problem with alcohol or drugs? __ Yes __ No

Describe how you feel about your body and general health:
____
____

Do you currently have a doctor you see? __ Yes __ No

List any surgeries, hospitalizations, accidents or serious illnesses and dates:
____
____

Have you ever attempted or considered suicide? ___ Yes ___ No

If yes, please provide details you feel comfortable sharing:
____
____

Do you or have you practiced in cutting? ___ Yes ___ No

If yes, please provide any comments or thoughts:______________________
____

What kind of support system do you have? __________________________
____

Is there anything else you think I should know prior to beginning your treatment?____
____
____

How did you find out about my services?
____

If using:
Insurance:____
ID# ____
Group# ____