Client Intake

Name, age and relationship of persons living in your household:_____

_____

_____

_____

Names and ages of children:_____

_____

_____

If not living with you, where do they live and how often do you see

them?:_____

_____

How long have you lived in this area:_____

Person to contact in case of emergency:_____

_____

Address City State Zip Code Phone #

Whom may I thank for this referral:_____

Have you ever been seen by a counselor/therapist/psychiatrist before:_____

List and Give Dates:_____

_____

Why did you terminate?:_____

Have you or do you participate in any 12 step program? If yes, which ones and when?

Why did you stop attending?: _____

_____

Are you taking **any** medication now?_____ List:_____

_____

List all tranquilizers or anti-depressants you have taken in the past: _____

_____

Have you ever been hospitalized for psychiatric (emotional) reasons? If so, why and when? _____

Have you ever thought about or attempted to kill yourself; when?:_____

_____

Have you ever physically abused yourself?:_____ Explain:_____

_____

Have you ever been sexually molested? (Include attempts):_____

_____

Have you ever been raped? (Include attempts):_____

_____

Has your partner been raped?:_____ Were you in a relationship with him/ her at the time?: _____

Have you ever been a victim of a violent crime?:_____

_____

Have you ever been involved in a battering relationship? Explain: _____

_____

Have you ever had an abortion or has your child been aborted?:_____

What effect has that had on you?:_____

_____

Name and address of your physician:_____

_____

Address City State Zip Code Phone Number

Have you ever had any of the following illnesses? Please answer yes or no and give the date(s):

Allergies (name)_____ Liver trouble_____
Seizures_____ Back injury/chronic pain_____
Thyroid trouble_____ Asthma_____
Fainting spells_____ Head injuries_____
Heart trouble_____ Gastritis/ulcers_____
Cancer_____ High Blood Pressure_____
Frequent headaches_____ Anemia_____
Diabetes_____ Kidney Disease_____
Anxiety attacks_____ PMS_____
Frequent yeast infections_____Compulsive overeating_____
Life threatening illness(name)_____
Other_____

SUBSTANCE USE

What is your history and current use/abuse of the following substances: alcohol, illegal drugs, prescriptions drugs, tobacco and caffeine?:_____

_____

PRELIMINARY BACKGROUND INFORMATION

How were you disciplined?_____

_____

Were you ever physically abused as a child by anyone?:_____

_____

How many times have you been married?:_____ How long?: _____

How many other significant relationships?:_____ How long? :_____

Are you in a significant relationship now?:_____ If yes, how long?_____

How would you describe your relationship?_____

Do you have any of the following symptoms? On the following two pages, please check the symptom and describe how often it is a problem it is for you. If it has only been a problem recently, indicate how long it has been a problem.

Are These True for you?

Are These True for You?	Never	4x/yr or less	More than 4x/yr	1xmo. Or more	1x/wk or more
Have too much energy					
Feel down-hearted and blue					
Have crying spells or feel like having them					
Have trouble sleeping at night					
Sleep more than 8 hours in a 24 hr. period					
Temper is explosive					
Isolate from others					
Have phobias or fears					
Feel that people control your actions					
Feel that you can read other peoples' minds					
Hear voices when no one is there					
Enjoy time alone					
Have homicidal thoughts or attempts					
Use sex to make you feel better					
See visions					
Spend time with you friends					
Have special powers					
Vomit or take laxatives to control weight					
Feel that people can read your mind					
Lose money gambling					
Feel that people are out to harm you					
Eat too much or too little					
Enjoy sex					
Notice that you are losing weight					
Have trouble with constipation					
Heart beats faster than usual					
Get tired for no reason					
Have difficulty concentrating					
Find it difficult to do the things you used to					
Restless and can't keep still					
Feel hopeful about the future					

Are These True for you?

Are These True for You?	Never	4x/yr or less	More than 4x/yr	1xmo. Or more	1x/wk or more
More irritable than usual					
Find it difficult to make decisions					
Feel that you are useful and needed					
Feel that others would be better off if you were dead					
Have intense mood swings					
Stay up all night or for days in a row					
Have flashbacks to past painful experiences					
Have nightmares					
Have lapses of memory					
Say or do things that are out of character					
Routinely work more than 50 hrs. per week					
Spend money to make you feel better					
Concerned about your weight					
Life is pretty full					

CURRENT SITUATION

Please state briefly what is troubling you now.

_____

_____

_____

_____

What would you like to accomplish in therapy?_____

_____

_____

_____

_____

Thank you for filling out this form. It will be very helpful in your evaluation. Add any additional comments below that you would care to make._____

_____

_____

_____

_____

_____

_____

_____

_____

On page 9 & 10, there are life circumstances that can cause stress to you or other significant people in your life. They are not necessarily negative, but may be viewed as negative by some people in society. Put an “X” in the appropriate space if these circumstances have occurred.

You can use the Comments section to give more detail (identify which sibling, etc.) or add other significant people who qualify under these classifications.

The Female symbol on the top row refers to the maternal side of your family and the Male to the paternal side. Even if the stressors happened before you were born they may have impacted your parents.
Do your best. You don’t have to interview your whole family. just what you know about.