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Client Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring this form with you to the first session. Thank You!

NAME: _____ **MALE/FEMALE:** _____ **DATE:** _____

DATE OF BIRTH: _____ **AGE:** _____

ADDRESS: _____ _____

TELEPHONE: H: _____ **Cell:** _____
W/Off: _____ _____**FAX:** _____

Okay to leave a phone message? Yes_____ **No**_____
E-mail: _____

Okay to contact/send mailings to you via email? Yes_____ **No**_____

Please briefly describe the reason you are seeking counseling services at this time
_____
_____
_____
_____
_____
_____
_____
_____
_____

HIGHEST GRADE completed in school: _____ _____

ETHNIC ORIGIN_____ **FIRST LANGUAGE** _____

PERSON & PHONE NUMBER TO CALL IN EMERGENCY: _____

How did you find out about my services? _____

OCCUPATION (former if retired): _____

IF UNEMPLOYED – FOR HOW LONG/REASONS?

_____

CIRCLE THAT WHICH APPLIES:
MARRIED/SINGLE/DOMESTIC PARTNERED/DIVORCED/SEPERATED/WIDOWED

NUMBER OF CHILDREN IF ANY_____ _____

NAME OF SPOUSE/PARTNER _____

RELIGIOUS/SPIRITUAL AFFILIATIONS_____

Estimate the severity of your problem: PLEASE CIRCLE:

Mild-Moderate-Severe-Very severe

MEDICAL DOCTOR (name /phone): _____

Okay to contact your medical doctor to assure coordination of care? Yes_____ No___

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

_____

_____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

_____

_____

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)_____

_____

_____

_____

PLEASE LIST ANY PRIOR MENTAL HEALTH DIAGNOSIS AND ANY RELEVANT FAMILY HISTORY: _____

_____

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name of therapist, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

_____

_____

_____

_____

_____

_____

_____

PLEASE LIST PREVIOUS PSYCHIATRIC HOSPITALIZATIONS – INCLUDE DATES AND REASON FOR ADMISSION(S) _____

_____

_____

ARE YOU CURRENTLY RECEIVING COUNSELING FROM ANOTHER THERAPIST? _____
IF YES, PLEASE PROVIDE THE NAME OF YOUR CURRENT THREAPIST AND PHONE NUMBER AND REASON FOR TREATMENT: _____

_____

_____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

_____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time _____

_____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTES? (If you answer Yes, please explain

_____

_____

_____

_____

_____

Please discuss your relationship to technology – do you use social networking like Face book, texting? If so how much and indicate if it is a problem for you at this time

_____
_____
_____
_____
_____

Please describe what you would like to achieve from counseling services (we will talk more about treatment goals once counseling has started):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please include any additional information you would like me to know about you and your situation:

_____
_____
_____
_____
_____
_____

Client signature_____ **Date**_____

Please complete this form and bring it with you to the session.
Thank You!