

Client Intake History

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Instructions: To assist in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Contact

Today's Date: _____

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Other (Identify): _____

Contact

Today's Date: _____

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Other (Identify): _____

Preferred Method of Contact:

Home

Is it okay to phone? Yes No

Is it okay to leave a message? Yes No

Cell

Is it okay to phone? Yes No

Is it okay to leave a message? Yes No

Is it okay to text? Yes No

Other

Is it okay to phone? Yes No

Is it okay to leave a message? Yes No

Email address: _____

Counseling History and Current Concerns

Have you received counseling in the past? Yes No

Provider	When	Location	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What was helpful about this experience? What was not helpful? _____

What brought you to seek counseling at this time?

How long has this issue been present in your life (please try to be specific)?

What have you done to try to resolve these issues? What has/has not been helpful?

Hobbies/Activities

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your three greatest personal strengths? _____

Demographic Information

Age: _____

Educational Background:

High School Alternative School GED Not in school

What school do you attend?: _____

Employment:

Are you currently employed? Yes No Full Time Part Time

Gender:

Female Male Transgender Non-binary Gender-Fluid

Other (Identify): _____

Gender at Birth:

Female Male Intersex

Preferred Pronouns: _____

Sexual Orientation:

Heterosexual Bisexual Gay/Lesbian Queer Questioning

Pansexual Other (Identify): _____

Relationship Status:

Single Dating

Cultural/Racial Background:

Caucasian Black or African American American Indian or Alaska Native

Hispanic/Latino Asian Hawaiian/Pacific Islander

Biracial/Multiracial (Identify) : _____

How important is your ethnic/cultural background? _____

Were you and both your parents born in the USA? ? Yes No

Religion/Spirituality

How do you identify yourself religiously or spiritually?

As a child: _____

As an adult: _____

How important is your religion/spirituality in your life? Why or why not? _____

Family Background

Please list members of your family including parents/guardians, step parents, siblings, partners/significant others, children, etc.:

Name	Relationship	Age	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list other individuals whom you consider important in your life:

Name	Relationship	Age	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Among these people, whom do you feel closest to, or that you can count on for support?

Current Relationship

Name: _____ Age: _____ Length of Relationship: _____

Please rank the following statements (1=Strongly Disagree, 2= Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree)

1. I am happy in my current relationship	1	2	3	4	5
2. I enjoy spending time with my partner	1	2	3	4	5
3. I trust my partner	1	2	3	4	5
4. My partner and I communicate well	1	2	3	4	5
5. I feel loved by my partner	1	2	3	4	5
6. Our friends and family support us as a couple	1	2	3	4	5
7. I am committed to continuing our relationship	1	2	3	4	5
8. I feel supported by my partner	1	2	3	4	5
9. I feel we handle conflict effectively	1	2	3	4	5
10. I love my partner	1	2	3	4	5
11. I feel safe with my partner	1	2	3	4	5
12. I feel respected by my partner	1	2	3	4	5

Emotional Health

Are you currently experiencing strong emotions which may include thoughts of suicidal ideation, self harm, or thoughts of harming others? Are you currently participating in self harm practices?

Yes No

If yes, please explain: _____

Have you ever had thoughts of harming yourself? Yes No

If yes, please explain: _____

Have you ever harmed yourself without suicidal intent? Yes No

If yes, please explain: _____

Have you ever experienced suicidal thoughts or attempted suicide? Yes No

If yes, please explain: _____

Have you ever been hospitalized for a mental health condition? Yes No

If yes, please explain: _____

Have you ever been physically, verbally, emotionally, or sexually abused? Yes No

If yes, please explain: _____

Have you ever had thoughts of harming or attempted to harm another person? Yes No

If yes, please explain: _____

Are you currently experiencing any of the following concerns? Please mark all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> depressed mood | <input type="checkbox"/> anxiety | <input type="checkbox"/> life transition |
| <input type="checkbox"/> crying | <input type="checkbox"/> panic attacks | <input type="checkbox"/> financial concerns |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> racing thoughts | <input type="checkbox"/> housing problems |
| <input type="checkbox"/> low energy | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> problems with family |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> impulsive thoughts | <input type="checkbox"/> problems with friends |
| <input type="checkbox"/> problems with appetite | <input type="checkbox"/> easily distracted | <input type="checkbox"/> problems with school |
| <input type="checkbox"/> problems with sleep | <input type="checkbox"/> irritability | <input type="checkbox"/> problems with work |
| <input type="checkbox"/> feeling angry | <input type="checkbox"/> restlessness | <input type="checkbox"/> not taking part in enjoyable activities |
| <input type="checkbox"/> mood swings | <input type="checkbox"/> poor concentration | <input type="checkbox"/> bingeing and/or purging |
| <input type="checkbox"/> aggressiveness | <input type="checkbox"/> feeling overwhelmed | <input type="checkbox"/> body dysmorphia |
| <input type="checkbox"/> low motivation | <input type="checkbox"/> worry | <input type="checkbox"/> gender dysphoria |
| <input type="checkbox"/> low self esteem | <input type="checkbox"/> distrust | <input type="checkbox"/> <u>History or Current:</u> |
| <input type="checkbox"/> worthlessness | <input type="checkbox"/> obsessions/compulsions | <input type="checkbox"/> emotional trauma/abuse |
| <input type="checkbox"/> guilt | <input type="checkbox"/> phobias | <input type="checkbox"/> physical trauma/abuse |
| <input type="checkbox"/> grief | <input type="checkbox"/> paranoia | <input type="checkbox"/> sexual trauma/abuse |
| <input type="checkbox"/> feeling isolated | <input type="checkbox"/> hallucinations | |
| <input type="checkbox"/> Other (describe): _____ | | |

Do you have a family history of mental health issues? Yes No

If yes, please explain: _____

Substance Use History

How frequently do you use alcohol? _____

When you drink alcohol, how much do you drink? How often? _____

Have you used any drug in the past 30 days that was not prescribed by a doctor? Yes No

Please explain: _____

Has a family member ever struggled with alcohol/drug use? Yes No

Please explain: _____

Medical History and Concerns

Primary Care Provider:

Name	Location	Phone
_____	_____	_____

How would you describe your general overall health? _____

Current Medication	Reason for medication
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized for a physical condition? Yes No

If yes, please explain: _____

Do you experience any recurrent or chronic physical conditions? Yes No

If yes, please explain: _____

Is there a history of any physical or mental developmental delays? Yes No

If yes, please explain: _____

Legal History

Please identify any history of legal involvement (arrests, probation, etc): _____
