Client Intake History

Brianna Dexter, LMFT
100 Sawmill Rd., Suite 3101
Lafayette, IN 47905

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): ________________________

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
______________	________	________	______________
______________	________	________	______________

Are you currently taking part in other psychiatric or counseling services? ☐ 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 ☐ GED ☐ Vocational ☐ Some College ☐ Associate's Degree ☐ Bachelors Degree ☐ Graduate Degree ☐ Post-Graduate Degree

Are you currently a student? ☐ Yes ☐ No Area of Study?______________________

Employment:

Are you currently employed? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Occupation: _______________________ How long? _______________________

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Branch: __________

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 ☐ Cohabiting ☐ Married ☐ Partnered

☐ Polyamorous ☐ Separated ☐ Divorce in process ☐ Divorced

☐ Widowed

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)

Statement					
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. I am physically attracted to my partner	1	2	3	4	5
5. My partner and I communicate well	1	2	3	4	5
6. I feel loved by my partner	1	2	3	4	5
7. Our friends and family support us as a couple	1	2	3	4	5
8. I am committed to continuing our relationship	1	2	3	4	5
9. I feel supported by my partner	1	2	3	4	5
10. My partner and I have similar world views	1	2	3	4	5
11. I find our sexual relationship fulfilling	1	2	3	4	5
12. I feel we handle conflict effectively	1	2	3	4	5
13. I love my partner	1	2	3	4	5
14. My partner and I share similar future goals	1	2	3	4	5
15. I feel safe with my partner	1	2	3	4	5
16. 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

- ☐ depressed mood
- ☐ crying
- ☐ hopelessness
- ☐ low energy
- ☐ fatigue
- ☐ problems with appetite
- ☐ problems with sleep
- ☐ feeling angry
- ☐ mood swings
- ☐ aggressiveness
- ☐ low motivation
- ☐ low self esteem
- ☐ worthlessness
- ☐ guilt
- ☐ grief
- ☐ feeling isolated
- ☐ anxiety
- ☐ panic attacks
- ☐ racing thoughts
- ☐ hyperactivity
- ☐ impulsive thoughts
- ☐ easily distracted
- ☐ irritability
- ☐ restlessness
- ☐ poor concentration
- ☐ feeling overwhelmed
- ☐ worry
- ☐ distrust
- ☐ obsessions/compulsions
- ☐ phobias
- ☐ paranoia
- ☐ hallucinations
- ☐ life transition
- ☐ financial concerns
- ☐ housing problems
- ☐ problems with family
- ☐ problems with friends
- ☐ problems with school
- ☐ problems with work
- ☐ not taking part in enjoyable activities
- ☐ binging and/or purging
- ☐ body dysmorphia
- ☐ gender dysphoria

History or Current:

- ☐ emotional trauma/abuse
- ☐ physical trauma/abuse
- ☐ sexual trauma/abuse

☐ Other (describe): ______________________________

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

If yes, 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
______________________	______________________________________
______________________	______________________________________
______________________	______________________________________

Did you experience any notable developmental delays? ☐ Yes ☐ No

If yes, please explain: ____

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

If yes, please explain: ____

Are you currently experiencing any physical concerns?
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

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No

Has your alcohol/drug use ever been a problem in the past? ☐ Yes ☐ No

Have you ever sought out treatment for your alcohol/drug use? ☐ Yes ☐ No

Have others in your life ever considered your alcohol/drug use a problem? ☐ Yes ☐ No

How has your substance use or the use of those around you affected your interpersonal relationships (parents, siblings, friends, significant others, etc.) or daily functioning (work or other responsibilities, etc)? ☐ Yes ☐ No

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

Legal History

Do you have a history of legal involvement? ☐ Yes ☐ No

If yes, please explain: ____