CLIENT INTAKE FORM

Today's Date _____

A. Client's Name _____ Age _____ Birth date _____
Parent/Guardian's name(s) _____Age(s) _____
Address _____
street city province postal code
Phone (home) _____ (work) _____ best time to call _____
MaritalStatus: ☐ single ☐ engaged
☐ married (how long _____) times married _____
☐ separated (how long _____) ☐ divorced (how long _____)
Education _____ Occupation_____
Spouse's Name _____ Age ____ Birth date _____
Spouse's Education _____ Spouse's Occupation _____

B. List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth date	Sex	Relationship	At Home?
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____
_____	_____	___	_____	_____

C. Who is coming for counseling? _____ Any prior counseling?
☐ Yes ☐ No If yes, when? _____ Where? _____ With whom? _____
Why? _____

Are you, or another family member, currently seeing a psychiatrist or another counselor? ☐ Yes ☐ No
If so, what family member? _____Name of helper _____ For what purpose? _____ Person to contact in emergency (name, relationship, phone, address) _____
_____

<u>Please fill out the following information as it applies to the client</u>

D. State the nature of the problem in your own words:

_____

_____

_____

_____

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

E. CRISIS INFORMATION: Any current suicidal thoughts, feelings, or actions?
☐ Yes, ☐ No If yes explain:_____
Any current homicidal or assaultive thoughts of feelings or anger-control problems: ☐ Yes ☐ No If yes, explain: _____
Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior?
☐ Yes ☐ No If yes, describe: _____
Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? ☐ Yes ☐ No If yes, describe _____

F.MED1CAL INFORMATION: Doctor's name, address, and phone _____
_____

Are you presently taking any medication: ☐ Yes ☐ No If so, what? _____
For what purpose? _____
Any problems with ☐ eating ☐ sleeping ☐ chronic pain ☐ recent weight changes
Describe any answers checked above: _____
Any other medical problems? _____
Have you or a family member ever been hospitalized for mental or emotional illness? ☐ Yes ☐ No If yes, please explain - dates, place, reason: _____
_____

G. Common problem/symptom checklist.
Fill in: O = none; 1 = mild, 2 = moderate, 3 = severe.

___ marriage	___ divorce/separation	___ alcohol/drugs
___ God/faith	___ premarital	___ child custody
___ other addictions	___ church ministry	___ singleness
___ disabled	___ grief/loss	___ past hurts
___ sexual issues	___ work/career	___ depression
___ codependency	___ family	___ school/learning
___ fear/anxiety	___ intimacy	___ children
___ money/budgeting	___ anger control	___ communication
___ parents	___ aging/dependency	___ loneliness
___ self-esteem	___ in-laws	___ weight control
___ mood swings	___ stress management	

Other (specify): _____

H. Who referred you to us? (name, relationship, and phone number _____
_____

If a professional referred you to us, may we send them a thank-you, noting your contact? ___ Yes ___ No
If yes, we will only send a thank-you, any other contact will require your express written permission.

THANK YOU for taking the time to fill out this information sheet. Your counselor will review this with you in the first session and use it to best assist you in your counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in the informed consent document.