# CLIENT INFORMATION Date _____

## Intake Information for Adult

Name _____DOB_____

Address _____Apt. _____ Home Phone _____

City _____State _____ Zip _____ Work Phone _____

Employer/School _____Occupation/Studying _____

Emergency contact information_____

_____

Cell Phone _____ Email _____

## Referral Information

How did you hear about my services? Please mark the option that applies:

___ Internet
___ Referral from a friend or family member
___ School staff
___ Another mental health professional
___ Other, please specify:
_____

If someone referred you to me, may I thank this person for the referral? Yes ___ No ___

## Family Information

Relationship Status: Single ___ Married ___ Partnered ___ Divorced ___ Widow/Widower ___

This is my: 1st ___ 2nd ___ 3rd ___ 4th ___ marriage or partnership

Number of children and their ages: _____

_____

Were/are your parents: Divorced ___ Never Married ___ Still Married ___ Widowed ___

Where are you in the birth order of siblings in your family? _____

Is there a family history of:

Depression Suicide Attempts Anxiety Eating Disorders Mental Illness

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction

Chronic Illness Other, please specify _____

Please explain any chronic illness

_____

_____

Please provide the following information for your family.

| | First Name | Current Age or Age at Death | Illness or Cause of Death | Occupation |
|---|---|---|---|---|
| Parent/Guardian | | | | |
| Parent/Guardian | | | | |
| Step-Parents | | | | |
| Grandparents | | | | |
| Uncles/Aunts | | | | |
| Brothers | | | | |
| Sisters | | | | |

## Social/Relationship Information

Please indicate any of the following that you have experienced.

| Death of: | Your age : |
|---|---|
| Mother | |
| Father | |
| Child | |
| Sibling | |
| Other significant person in your life | |

| Other events: | Your age: |
|---|---|
| Desertion of Mother | |
| Desertion of Father | |
| Divorce of Parents | |
| Sexual / Emotional / Physical Abuse | |
| Violence in the Family | |
| Mental Illness of Family Member | |

How do you get along with your present spouse or partner? _____

_____

How do you get along with your children? _____

_____

How do (or did) you get along with your family of origin?

Mother _____

Father _____

Siblings _____

Please list your significant friends and indicate how long those friendships have been in place.

| First Name | How Long | How often do you see this friend? |
|---|---|---|
| | | |
| | | |
| | | |

What do you consider your strengths? _____

_____

_____

What are your interests (hobbies, etc.) _____

_____

## Spiritual Resources

How significant a role does spirituality play in your life?

None _____ Somewhat important _____ Significant _____ Very Significant _____

Religious Orientation or Spiritual Practice _____

_____

## Employment Information

Current occupation _____ How long at current job? _____

How satisfied are you in your job?

Not Satisfied ___ Somewhat Satisfied ___ Comfortable ___ Very Satisfied ___

Are you satisfied that the income from your job adequately covers your living expenses?

Not Satisfied ___ Somewhat Satisfied ___ Comfortable ___ Very Satisfied ___

Do you have other sources of income? Yes ___ No ___

If yes, please describe _____

## Medical Information & History

Primary Physician _____ Phone _____

Date of Last Exam _____

Major or Chronic Illnesses/Injuries

_____

_____

Operations

_____

| Current Medications | Dosage | Frequency | Effectiveness | Prescribing Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have there been recent changes in any of the following areas?

Sleep Dreams/Nightmares Amount of Exercise Eating/Appetite Weight Sexual Desire

Please describe the change:

_____

How would you characterize your overall health?

Poor Fair Good Excellent

Do you smoke? Yes ___ No ___ # cigarettes/day ___ Have you smoked in the past? Yes ___ No ___

Age you began smoking and age when you quit (if applicable) _____

Do you consume alcohol? Yes ___ No ___ If so, how much:

Less than 1x/month ___ 1-3x/month ___ 1x/week ___ Several x's/week ___ Every day ___

Check all that apply: ___ Beer ___ Wine ___ Hard Liquor

Do you use any street drugs or misuse prescription drugs? Yes ___ No ___ If yes, list:

| Name of Drug | Frequency of Use |
|---|---|
| | |
| | |
| | |

## Counseling/Psychotherapy Information

Please describe the main concerns that prompted you to seek counseling/psychotherapy?

_____

_____

How have these concerns evolved or changed over time?

_____

_____

Please indicate what major stressors you have had in the last 12 months.

Serious Illness or Injury ___ Death of a Close Friend or Family Member ___ Major Illness in Family ___

Gain of New Family Member ___ Physical Move ___ Divorce/Separation ___ Job Change ___

Other _____

Have you ever had thoughts of suicide? Yes ___ No ___ Are you currently? Yes ___ No ___

Have you ever attempted suicide? Yes ___ No ___ If so, when? _____

What would you like to be different in your life when you are done with therapy?

_____

_____

Have you ever received psychological or psychiatric counseling before? Yes ___ No ___
If so, please describe when, from whom, the purpose and results:

_____

_____

Have you ever been prescribed medicine for psychiatric or emotional problems? Yes __ No __
If so, please describe when, the prescribing clinician, what medication, for what, and the results:

_____

_____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes ___ No ___
If so, please describe when, where, for what reason, and the results:

_____

_____

Have you ever been in a drug or alcohol rehab program? Yes ___ No ___
If yes, how many times? ___ When? _____ Inpatient ___ Outpatient ___ How long? ___

Outcome? _____

_____

Is there anything else you think I should know before I begin working with you?

_____

_____

_____

_____

_____

**Thank you for your time in filling out this information.**

**I look forward to working with you.**