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Client Intake Information

CLIENT INFO	EMPLOYER & STATUS
Date of Birth: _____/______/______	Company: ________________________
Name:______________________________	Address: ________________________
Address:____________________________	City: ______________Zip: __________
City:____________________ Zip:__________	I am Self Employed
Home #______________ Cell#______________	I am unemployed
Work #______________ Other #______________	I am retired
On what number may we leave a confidential message: ____________	I am: Single Married Divorced
Is it okay to text you? Y N	
** (Only used for the most efficient communication regarding appointment date, times and rescheduling)	How many people live in your household? __________

EMERGENCY CONTACT INFO

Notify: ________________________ Phone: ________________________

Relationship to client: ____

HEALTH AND MEDICAL

Primary Care Physician: ____________________________ Phone: ________________

Psychiatrist: ____________________________________ Phone: ________________

Please list any medical problems: ____

Please list any current medications: ____

Insurance: ____________________________ Insured: ________________________

ID #: ______________________________

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT?

50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
8am, 9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding?

Client ID#________________________________

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them at your intake meeting.

I AM EXPERIENCING…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Frequent worry or tension					
Fear of Many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual feelings about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Decreased interest in pleasurable activities					
Social isolation, Loneliness					
Suicidal thoughts					
Bereavement or feeling of loss					
Changes in sleep (too much or not enough					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
I am Angry, Irritable, Hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

Client ID#________________________________

I HAVE…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequences					
Been physically harming myself					
Been violent towards other's					

I USE THE FOLLOWING…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Restriction of food consumption					
Binging and purging					
Binge eating					
A lot of weight loss or gain					

I HAVE…	SELDOM	OFTEN	ALWAYS	NEVER	FOR HOW LONG?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

Client ID#________________________________

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness?	**YES**	**NO**
Has a close relative ever been hospitalized for a psychiatric illness?	**YES**	**NO**
Does anyone in your family have a mental illness?	**YES**	**NO**
Has anyone in your family every attempted or committed suicide?	**YES**	**NO**
Does anyone in your family have a substance abuse problem?	**YES**	**NO**
Have you ever been arrested?	**YES**	**NO**

1) How well you are doing on your job:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

2) How well you are doing in your marital/significant other relationship:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

3) How well you are doing in your family relationships:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

4) How well you are doing in relationships with people outside your family:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

5) Please rate your current physical health:

0	1	2	3	4	5	6	7	8	9
Very Poor									Excellent

6) Please rate your general happiness and well-being:

0	1	2	3	4	5	6	7	8	9
Very Poor									Excellent