Intake Form

Client Name:_____Date:_____

Age:_____Sex:_____Date of Birth_____

School/Employer_____

If child, then parents names_____

_____

Who referred You?_____

Directions: Please answer the following questions as fully as possible.

Presenting Problem-what brings you in to office today:

Symptoms (please circle all that apply)

Change in sleep pattern	Difficulty concentration	Change in appetite
Excessive worry/fear	Decreased energy	Suicidal feelings
Decreased motivation	Sad most of the day	hyperactive most of the day
Loss of interest	Significant weight loss	Feelings of worthlessness
Recurrent thoughts of death	Irritability/agitation	Grief issues
Self injury (cutting)	hair pulling	nail biting/skin picking
Binging	purging	marital issues
Stress	anger/temper	
Physical symptoms attributed to panic attacks		

Childhood disorders (please circle all that apply)

Oppositional	Disruptive	learning problems	language problems
adjustment issues	parent/child issues	fire setting	developmental delay
Gang involvement	cruelty to animals	abuse issues	attachment issues
Attention deficit	easily distracted	impulse control	

Other_____

Further explanation of any area circled above (frequency and duration)

Circle any losses you have experienced in the last year:

Family member_____ Health Spouse/Significant other Job

Child Disruption of lifestyle

Suicidal Ideation

Have you ever attempted to commit suicide in the past? _____

If yes, how/when?_____

Is there a history of suicide in your nuclear and/or extended family?_____

Have you ever inflicted burns or wounds on your self?_____

Are you presently suicidal?_____

Mental health history

List any previous outpatient counseling experiences:

Place_____Reason_____

Length of time_____Dates_____

Place_____Reason_____

Length of time_____Dates_____

Have you ever been admitted to the hospital for mental health or addiction issues?_____

Place_____Reason_____

Length of time_____Dates_____

Name of current psychiatrist_____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep:

_____

_____

Current Medical Problems (include all current medications, herbs, dosage and prescribing physician and include date of last physical exam)

Substance Abuse

Have you ever been arrested for DUI/DWI?	Yes____	No____
Have you ever been arrested for possession, sale/solicitation?	Yes____	No____
Have you ever been to a drug treatment program?	Yes____	No____
Have you ever experienced a blackout?	Yes_____	No____

Describe your current usage or usage within the last year of alcohol, tobacco, caffeine, pornography, gambling, illicit drugs, pain medication(please list the substance, the amount, the frequency, the ago of first use, the age regular use started and the date of last use)

Describe any significant family history of substance abuse:

Legal/Criminal History

Nutrition:

Any recent changes in eating habits?_____

Has your weight fluctuated more than ten pounds in the last year?_____

Do you often eat out of depression/boredom/anger?_____

Do you ever self-induce vomiting?_____

Do you ever binge eat or feel your eating is out of control?_____

Do you use laxatives/water pills/or diet medications?_____

Developmental History:

List members of your family you grew up with and how you got along

How would you describe your childhood? Traumatic Painful Uneventful

What were you like as a child? (include friendships, hobbies and personality)

Were there any unusual or traumatic experiences for you as a child? (Please list the age of which they occured)

Current Living Situation(names and ages of those living with you)

Marital History (list current and prior marriages, age of spouse, any children from each relationship)

Family History of Mental Health

Relative	Diagnosis	Treatment
__mother		
__father		
__brother		
__sister		
__other relative		

Work History

Please describe current job/career, job satisfaction, relationship with co-workers, job performance and number of jobs you have had in last 5 years)

Is there anything else you feel that I need to know about you?_____

_____

What are your expectations from counseling?_____

_____

_____

How would you complete the following sentence? *If*_____

_____*happened everything would be better.*

Client/guardian signature_____

Child/Adolescent Addendum

(to be completed if you are bringing a child in for treatment)

Describe how the child's condition is affecting the family:

Current school status(grade level. If not enrolled, why? Type of class, regular/special ed, include any barriers to learning, list any grades repeated, honors received):

Conduct Issues

Likes and dislikes about school:

Developmental History:

Full term?_____Any complications during pregnancy or delivery?_____

_____

Any delays in physical growth or development?_____

Any history of trauma, abuse or neglect?_____

Any history of head trauma/loss of consciousness?_____

If yes, date and treatment?_____

Describe your child's social interactions: _____

_____

_____

Describe your child's emotional development: (excessive crying, separation anxiety, how child handles stress or painful emotions)

Any recent changes with your child's daily living skills (grooming, hygiene, independence)

What are your child's strengths: _____

_____

What are your expectations of therapy?_____

_____