



Client Intake Form

Date / /

Name: _____ DOB: / / Age

Gender F M Other _____

Address: _____ TX _____
street address city zip code

Phone: (Cell) _____ (Home) _____ is it ok to leave messages? Yes No

E-mail: _____ Highest Education Attained: _____

Occupation: _____ Place of Employment: _____

Relationship Status: _____ Partner/ Significant Other's Name _____

age _____ occupation _____

Persons Living With You

<u>Relationship</u>	<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Quality of relationship</u>
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good
_____	_____	<input type="checkbox"/> F <input type="checkbox"/> M	_____	<input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good

Social Relationships

Check how you generally get along with other people: (check all that apply)

- Affectionate Aggressive Avoidant Fight/argue often Outgoing
 Follower Friendly Leader Shy/withdrawn Submissive

Other (specify): _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong/identify? _____

Spiritual/Religious

Any religious affiliations/beliefs Yes No _____ Practicing: Yes No

How important are spiritual matters to you? Not Somewhat Moderately Very

Comments _____

Legal

Are you currently or have you ever been involved any **active cases** (traffic, civil, criminal)?

- Yes No Are you presently on probation or parole? Yes No

Military

Military experience? Yes No Combat experience? Yes No

Comments: _____

Medical

List any current health problems/concerns:

Current medications/ Dose	Purpose	Side effects
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychosocial History

Please check behaviors and symptoms which apply to you in the last four to six weeks.

- | | | |
|--|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> Compulsive Video Gaming | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Porn addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Other (specify): _____ | |

Do you ever drink alcohol? Yes No If yes, what and how often? _____

Use drugs? Yes No If yes, what and how often? _____

If you or anyone in your household has a history with any of the following, please select all that apply.

- | | |
|---|----------------------------|
| <input type="checkbox"/> Physical Abuse | Family member / age: _____ |
| <input type="checkbox"/> Sexual Abuse | Family member / age: _____ |
| <input type="checkbox"/> Emotional Abuse | Family member / age: _____ |
| <input type="checkbox"/> Neglect | Family member / age: _____ |
| <input type="checkbox"/> Drug Abuse | Family member / age: _____ |
| <input type="checkbox"/> Alcoholism | Family member / age: _____ |
| <input type="checkbox"/> Domestic violence | Family member / age: _____ |
| <input type="checkbox"/> Psychiatric difficulties | Family member / age: _____ |
| <input type="checkbox"/> Criminal difficulties | Family member / age: _____ |
| <input type="checkbox"/> Other: _____ | Family member / age: _____ |

Comments: _____

Suicide

Have you ever considered suicide? Yes No Attempted? Yes No

Have you considered suicide in the last 60 days? Yes No Attempted? Yes No

Are you currently considering suicide? Yes No

Have you ever received counseling/psychiatric treatment? Yes No

Comments: _____

GOALS

What are your goals for therapy?

Additional Information

Any other information you think your counselor should know?

Signature _____

Date _____