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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

Relationship	Name	Gender	Age	Quality of Relationship
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ Good
		❑ F ❑ M		❑ Poor ❑ Average ❑ 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❑ Follower ❑ Friendly ❑ Leader ❑ Shy/withdrawn ❑ Submissive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

Psychosocial History

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

❑ Aggression	❑ Elevated mood	❑ Phobias/fears
❑ Alcohol dependence	❑ Fatigue	❑ Recurring thoughts
❑ Anger	❑ Gambling	❑ Sexual addiction
❑ Antisocial behavior	❑ Hallucinations	❑ Sexual difficulties
❑ Anxiety	❑ Heart palpitations	❑ Sick often
❑ Avoiding people	❑ Compulsive Video Gaming	❑ Sleeping problems
❑ Chest Pain	❑ Hopelessness	❑ Speech problems
❑ Porn addiction	❑ Impulsivity	❑ Suicidal thoughts
❑ Depression	❑ Irritability	❑ Disorganized thoughts
❑ Disorientation	❑ Judgment errors	❑ Trembling
❑ Distractibility	❑ Loneliness	❑ Withdrawing
❑ Dizziness	❑ Memory impairment	❑ Worrying
❑ Drug dependence	❑ Mood shifts	❑ Eating disorder
❑ Panic attacks	❑ 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.

❑ Physical Abuse	Family member / age: ________________________________
❑ Sexual Abuse	Family member / age: ________________________________
❑ Emotional Abuse	Family member / age: ________________________________
❑ Neglect	Family member / age: ________________________________
❑ Drug Abuse	Family member / age: ________________________________
❑ Alcoholism	Family member / age: ________________________________
❑ Domestic violence	Family member / age: ________________________________
❑ Psychiatric difficulties	Family member / age: ________________________________
❑ Criminal difficulties	Family member / age: ________________________________
❑ 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______________________