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Client Intake Information

Client: _____ Date of Birth: _____

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Social Security #: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Business or Cell Telephone: _____

Marital Status: _____ Lives With: _____

Employer: _____ Length of Employment: _____

Referred by: _____ Annual Income: _____

Primary Care Physician_____Phone #_____

In case of emergency call_____Phone #_____

CURRENT PHYSICAL SYMPTOMS

Any health concerns: Yes No Sleep disturbance: Yes No

HISTORY

Is there substance abuse history in the family (other than self)? Yes No

Is there a history of alcohol or substance abuse by self? Yes No

Is there any psychiatric history in the family (other than self)? Yes No

Is there any psychiatric history for self? Yes No

Has there been physical abuse: Yes No Age(s): _____

Childhood Sexual abuse/incest? Yes No Age(s): _____

Sexual assault/rape? Yes No Age(s): _____

Has there been severe trauma in your life? Age(s): _____

RISK ASSESSMENT

Have there been current or recent suicidal thought(s)? Yes No
Has client ever made a suicide attempt in his/her life? Yes No
Has there been a friend or relative who attempted or completed suicide? Yes No
Has there been any current or past intent to cause damage or harm, threaten, intimidate or abuse another person? Yes No
Has client had any recent losses? Yes No
Does client have someone he/she can rely on in a crisis? Yes No
Does client have any thinking, cognition, memory problems? Yes No
Does client have any impulse, reckless or aggressive behavior issues? Yes No
Are there concerns about job or school performance? Yes No

PRESENT CONCERNS

Issues of current concern (Check all that apply)

_____Marital problems _____Personal or individual concerns

_____Family problems _____Spiritual concerns

_____Parent/child problems _____Child/school problems

_____Loss of focus _____Addiction issues

_____Grief issues _____Discrimination issues

Briefly describe your goals for counseling:_____

_____

_____