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Counseling Intake Form

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Client's Name: _____ **Date**: _____

Primary reason(s) for seeking services today:

_____

_____

Please check behaviors and symptoms that occur more often than you would like them to:

___ Aggression
___ Alcohol dependence
___ Anger
___ Anxiety
___ Chronic Pain
___ Compulsive behavior
___ Concentration problems
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___Dizziness
___ Drug dependence
___ Eating disorder
___ Fatigue
___Flashbacks
___ Grief
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Hyperactivity
___ Impulsivity
___ Irritability
___ Loneliness
___ Memory impairment
___ Mood swings
___ Obsessive Thoughts
___ Panic Attacks
___ Phobias/Fears
___ Poor judgment
___ Self-Esteem Problem
___ Sexual Difficulties
___ Sleep problems
___ Social Withdrawal
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Unresolved Trauma
___ Worrying
___ Other (specify): _____
_____
_____

Employment

Please check employment status:

___ *employed full time* ___*employed part-time* ___ *unemployed* ___ *disabled* ___ *retired*

If currently employed, please list job information below:

Employer **Job Title** **How long there?**

_____ _____ _____

Family/Living Situation

___ Single ___ Partnered ___ Married ___ Separated ___ Divorced ___ Widowed

Name of Spouse or Partner: _____ Age: ___ How long together? _____

Children: _____ age: ____ Living with you? Yes No
_____ age: ____ Living with you? Yes No
_____ age: ____ Living with you? Yes No
_____ age: ____ Living with you? Yes No

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Counseling/Prior Treatment History

Have you had any prior professional counseling or psychiatric treatment? ___ Yes ___ No
If yes, please list most recent treatment episodes, who treated you, and outcome below

Approximate Treatment Dates	*Treatment Provider/Facility*	*Outcome*
_____	_____	_____
_____	_____	_____

Medication and Chemical Use History

Have you ever been treated for alcohol or drug dependence/abuse? ____ *Yes* ____ *No*

Have you ever felt like you should cut down on alcohol or other drug use? ____ *Yes* ____ *No*

Has a friend or relative ever discussed concerns about your drug use? ____ *Yes* ____ *No*

Have you ever felt guilty about your drinking or drug us? ____ *Yes* ____ *No*

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ *Yes* ___ *No*

Is there a history of problems with alcohol or drug use in your family? ____ *Yes* ____ *No*

Medical/Physical Health

List any current health concerns: _____

Primary Care Physician's Name and Phone Number: _____
_____

Current Prescribed Medications	**Dose**	**Frequency**	**Purpose**	**Side Effects**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family History/Development

List any pertinent family history of medical, mental health or substance abuse problems _____
_____
Have you ever been a victim of sexual, physical, emotional or verbal abuse? ____ Yes ____ No
Are there other unusual/traumatic circumstances that affected your development? ___ Yes ___ No
If Yes, please describe: _____
_____
_____

_____ _____
Therapist's Signature **Date**