

PATIENT / CLIENT INTAKE FORM

Welcome. To help me serve you better, I ask that you take a few moments to provide the following information as completely as possible. All information is subject to the rules of confidentiality. Feel free to write in longhand, but please do so legibly.

If you need more writing space, please use an extra piece of paper. Please do not leave any question blank. Place 'n/a' for any question that may 'not apply'.

PERSONAL INFORMATION

Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Today's Date _____

May we call you at your home? Yes _____ No _____

May we leave a message at your home? Yes _____ No _____

May we write you at your home? Yes _____ No _____

May we call you at your work place? Yes _____ No _____

May we leave a message at your work place? Yes _____ No _____

May we call and leave a message on your cell phone? Yes _____ No _____

May we use texting to communicate with you? Yes _____ No _____

Email Address _____

Date of Birth _____ Age _____ Male _____ Female _____

Social Security Number: _____

What is your current occupation? _____

Who referred you to the Center? _____

Who referred you to the specific counselor? _____

MARITAL HISTORY

Current Marital Status: Never Married _____ Married _____ Divorced _____

Separated _____ Widowed _____

Name of current spouse (if applicable) _____

Date of Marriage _____

Are you currently cohabitating? Yes _____ No _____

Do you consider your partner your common law spouse? Yes _____ No _____

Self

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
-------------------------	------------------	-----------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION

Did you graduate high school? Yes _____ No _____ GED? _____

If so, where? _____

If not, why not? _____

If not, what was the highest grade achieved? _____

Did you earn a college degree? Yes _____ No _____

If so, when, where, and in what? _____

Did you earn a graduate degree? Yes _____ No _____

If so, when, where, and in what? _____

Have you earned or are working toward a PhD or equivalent status? Yes _____

No _____. If so, in what? _____

What is your spouse's education Level? GED _____ High School Graduate _____

College Degree _____ Graduate Degree _____ PhD or higher. _____

Children Living in Household

Name	Gender	Age	Diagnosed ongoing problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children not living in household

Name	Gender	Age	Diagnosed ongoing problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

RELIGIOUS VALUES AND BELIEFS

Are you currently attending a church regularly? Yes ____ No ____

If yes, what is the name of the church? _____

What is the denomination of the church? _____

How active are you in faith related activities? _____

Do you consider yourself a born-again Christian? Yes ____ No ____ Unsure ____

Do you have a personal faith story: Yes ____ No ____ Unsure ____

Are religious or spiritual issues important in your life? Yes ____ No ____

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your current challenges? Yes ____ No ____

If yes, what are they? _____

If married, do you & your spouse have similar faith beliefs? Yes ____ No ____

Do you desire faith based methodologies be used during the counseling process? Yes ____ No ____

HEALTH INFORMATION

How would you rate your health? _____

On average, how many hours do you sleep each night? _____

Do you experience food cravings? Yes _____ No _____

If so, for what items? _____

How would you rate your diet? Healthy & wise _____ Healthy & ok _____

Average _____ Needs Improvement _____ Poor _____ Beyond Poor _____

Do you have an infectious disease? Yes _____ No _____ If so, what is it and how does it affect your life? _____

What allergies do you have? _____

Are you currently taking prescribed medication? Yes _____ No _____

If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Use back of sheet if more room is required.)

Please list whatever diagnosis you have been given in the last five years.

Are you currently self medicating? Yes _____ No _____

Do you have a history of drug or alcohol abuse? Yes _____ No _____

If so, please explain: _____

Do you or an immediate family member have a history of mental illness?

Yes _____ No _____. If so, what is it? _____

Are you presently experiencing any major life changes? Yes ____ No _____. If so, please explain briefly. _____

List any special needs you have. _____

Check the medical conditions or situations that apply presently or in the past:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gall bladder disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood born infection |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Illness |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Miscarriage(s) |

Have you ever had or been involved with an abortion? Yes ____ No ____

If yes, what was your involvement? _____

If yes, has the experience proven to be problematic for you? Yes ____ No ____

Other issues: _____

PERSONAL CONCERNS (that brings you to a professional counselor)

What issues are you seeking help for? _____

On a scale of one to ten (ten being the most), how much are you troubled by the issue identified above? _____

What have you previously done to correct the problems? _____

Are you presently seeing a counselor? Yes ____ No ____

If so, who? _____

If so, how often? _____

If so, for what? _____

Have you engaged in professional counseling before? Yes _____ No _____

If so, for each incidence you remember, please complete the following (use back of this page if needed.)

1. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

2. Who was the counselor? _____

What was the problem? _____

How many sessions over what period of time? _____

What were the results? _____

THOUGHTS AND BEHAVIORS

Please circle how often the following thoughts or behaviors occur. They are in no particular order, so please don't read too much into them. Answer them quickly and honestly.

	Never	Rarely	Occasionally	Often	Constantly						
Life is hopeless.	0	1	2	3	4	5	6	7	8	9	10
I feel lonely.	0	1	2	3	4	5	6	7	8	9	10
I feel like a failure.	0	1	2	3	4	5	6	7	8	9	10
Most people don't like me.	0	1	2	3	4	5	6	7	8	9	10
God is disappointed in me.	0	1	2	3	4	5	6	7	8	9	10
I can't be forgiven.	0	1	2	3	4	5	6	7	8	9	10
I want to die.	0	1	2	3	4	5	6	7	8	9	10
I want to hurt someone.	0	1	2	3	4	5	6	7	8	9	10
I am so stupid.	0	1	2	3	4	5	6	7	8	9	10
I am going crazy.	0	1	2	3	4	5	6	7	8	9	10
I can't concentrate.	0	1	2	3	4	5	6	7	8	9	10
I feel depressed.	0	1	2	3	4	5	6	7	8	9	10
Why am I so different?	0	1	2	3	4	5	6	7	8	9	10
I can't do anything right.	0	1	2	3	4	5	6	7	8	9	10
No one cares about me.	0	1	2	3	4	5	6	7	8	9	10
People hear my thoughts.	0	1	2	3	4	5	6	7	8	9	10
I feel no emotions.	0	1	2	3	4	5	6	7	8	9	10
Someone is watching me.	0	1	2	3	4	5	6	7	8	9	10
I hear voices in my head.	0	1	2	3	4	5	6	7	8	9	10
My behavior is out of control.	0	1	2	3	4	5	6	7	8	9	10

	Never	Rarely	Occasionally	Often	Constantly						
I have considered suicide.	0	1	2	3	4	5	6	7	8	9	10
I lose my temper easily.	0	1	2	3	4	5	6	7	8	9	10
I lose my temper often.	0	1	2	3	4	5	6	7	8	9	10
I argue with spouse.	0	1	2	3	4	5	6	7	8	9	10
I am easily annoyed by others.	0	1	2	3	4	5	6	7	8	9	10
I feel angry.	0	1	2	3	4	5	6	7	8	9	10
I feel spiteful, vindictive.	0	1	2	3	4	5	6	7	8	9	10
I instigate fights w/spouse	0	1	2	3	4	5	6	7	8	9	10
Spouse instigates fights w/me.	0	1	2	3	4	5	6	7	8	9	10
My emotions are out of control.	0	1	2	3	4	5	6	7	8	9	10
I feel like running way.	0	1	2	3	4	5	6	7	8	9	10
I feel emotionally abused.	0	1	2	3	4	5	6	7	8	9	10
Spouse's requests annoy me.	0	1	2	3	4	5	6	7	8	9	10
I blame others for my mistakes.	0	1	2	3	4	5	6	7	8	9	10
I don't pay attention to details.	0	1	2	3	4	5	6	7	8	9	10
I make careless mistakes.	0	1	2	3	4	5	6	7	8	9	10
I am easily distracted.	0	1	2	3	4	5	6	7	8	9	10
I feel fatigued.	0	1	2	3	4	5	6	7	8	9	10
I feel anxious &/or nervous.	0	1	2	3	4	5	6	7	8	9	10
I worry excessively.	0	1	2	3	4	5	6	7	8	9	10
I have trouble sleeping.	0	1	2	3	4	5	6	7	8	9	10
I worry over money.	0	1	2	3	4	5	6	7	8	9	10
I have suffered recent loss.	0	1	2	3	4	5	6	7	8	9	10
I am in conflict w/others.	0	1	2	3	4	5	6	7	8	9	10
I am using illegal drugs.	0	1	2	3	4	5	6	7	8	9	10
My alcohol consumption is ...	0	1	2	3	4	5	6	7	8	9	10
I am shy/avoidant/withdrawn.	0	1	2	3	4	5	6	7	8	9	10
I feel suicidal.	0	1	2	3	4	5	6	7	8	9	10
I have attempted suicide.	0	1	2	3	4	5	6	7	8	9	10
I feel loved.	0	1	2	3	4	5	6	7	8	9	10
I feel unloved.	0	1	2	3	4	5	6	7	8	9	10
I feel reasonably happy.	0	1	2	3	4	5	6	7	8	9	10
I am satisfied w/life.	0	1	2	3	4	5	6	7	8	9	10
I am not satisfied w/life.	0	1	2	3	4	5	6	7	8	9	10
God loves me.	0	1	2	3	4	5	6	7	8	9	10
I've experienced sexual trauma.	0	1	2	3	4	5	6	7	8	9	10
People take advantage of me.	0	1	2	3	4	5	6	7	8	9	10
I have difficulty making friends.	0	1	2	3	4	5	6	7	8	9	10
I hate myself.	0	1	2	3	4	5	6	7	8	9	10
I am ugly, homely.	0	1	2	3	4	5	6	7	8	9	10

	Never	Rarely	Occasionally	Often	Constantly						
I feel neglected.	0	1	2	3	4	5	6	7	8	9	10
I feel fearful for no reason.	0	1	2	3	4	5	6	7	8	9	10
I feel guilty.	0	1	2	3	4	5	6	7	8	9	10
My situation is hopeless.	0	1	2	3	4	5	6	7	8	9	10
I fear taking reasonable risk.	0	1	2	3	4	5	6	7	8	9	10
I self mutilate.	0	1	2	3	4	5	6	7	8	9	10
I feel abandoned.	0	1	2	3	4	5	6	7	8	9	10
I have trouble saying 'no'.	0	1	2	3	4	5	6	7	8	9	10
I have trouble sleeping.	0	1	2	3	4	5	6	7	8	9	10
I smoke.	0	1	2	3	4	5	6	7	8	9	10
I use illegal drugs.	0	1	2	3	4	5	6	7	8	9	10
I drink until I'm drunk.	0	1	2	3	4	5	6	7	8	9	10
I am really glad this is the last response 😊	2	3	4	5	6	7	8	9	10		

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently (more than 6) or are a concern to you. Use the back of this sheet if necessary.

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like them to take place.

- | | | |
|---|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Money Issues/Problems |
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Sick Often | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Antisocial Behavior | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Infidelity | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Trembling | <input type="checkbox"/> Judgment Errors | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Distractibility |
| <input type="checkbox"/> Memory Impairment | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mood Shifts |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Problems Concentrating |

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Elevated Mood |
| <input type="checkbox"/> Recurring Thoughts | <input type="checkbox"/> Tremors | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Stressed Out | <input type="checkbox"/> Over-Ambitious |
| <input type="checkbox"/> Difficulty Keeping Job | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Bedwetting |

Fears

- | | | |
|---|--|---|
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Obsessive Compulsive Habits | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Hysterical Reactions | <input type="checkbox"/> Disorganized Thoughts | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Delusions/Illusions | <input type="checkbox"/> Voices in My Head | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Avoiding People | | |

Stress/Depression

- | | | |
|---|--|---|
| <input type="checkbox"/> Coping Difficulty | <input type="checkbox"/> Physical Symptoms of Stress | <input type="checkbox"/> Inability to Adapt |
| <input type="checkbox"/> Burnout | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gloomy |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Feeling Sad | <input type="checkbox"/> Loss of Interest |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Helplessness | <input type="checkbox"/> Crying/Tearful |
| <input type="checkbox"/> Shame | <input type="checkbox"/> Difficulty Making Decisions | |
| <input type="checkbox"/> Exhausted, having nothing left to give anything/anyone | | |

Please give examples of how each of the symptoms that you checked impairs your ability to function (i.e., socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary. _____

What major losses or traumas have you experienced? _____

What do you believe the problem is for which you are seeking help? What started the problem? _____

What do you hope to achieve through the counseling process? In other words, what are your goals? _____

LEGAL ISSUES (Remember, confidentiality rules apply)

Have you ever been arrested? Yes _____ No _____. If so, what was the charge? _____

Have you ever been convicted of a crime? Yes _____ No _____. If so, what was the disposition? _____

Are you presently on probation or parole? Yes _____ No _____ If so, why?

Do you have any criminal or civil legal issues pending? Yes _____ No _____
If so, please explain briefly. _____

Have you or your immediate family members ever been involved with CPS, had a case or investigation opened? Yes _____ No _____ If so, when? _____
If so, who? _____
If so, please explain why: _____

Have you ever been the victim of domestic violence? Yes _____ No _____
If yes, when and by whom? _____

Have you witnessed domestic violence? Yes _____ No _____
If so, when and by whom? _____

Have you ever perpetrated or participated in domestic violence? Yes ___ No ___

If so, when? _____ How often? _____

Who was the victim(s)? _____

EMERGENCY CONTACT

Whom should we contact in case of emergency, to include threats of self harm or harm to others, or verify safety? **Note:** By providing information you are giving me your consent to contact the person indicated for the reasons mentioned.

Primary contact person (Typically a spouse or parent):

Name _____

Relationship to you _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Secondary contact person:

Name _____

Relationship to you _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Filling out this form is an important second step in addressing the issues that concern you. The first step was calling a counselor and asking for help. Perhaps unbeknown to you, your therapy has already begun. You are well on your way to good health!

Thank you for choosing us to serve you. We appreciate the opportunity.