PATIENT / CLIENT UPDATE INTAKE FORM

Welcome back! To help me serve you better, I ask that you take a few moments to provide relevant updated 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 workplace? Yes _____No _____

May we leave a message at your workplace? 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 _____

Has your occupation changed? Yes _____ No _____

MARITAL HISTORY

Current Marital Status: Has there been any changes in your marital status since your last appointment, to include changes in physical living arrangements?

Yes _____ No _____ If yes, please explain: _____ _____

_____

_____

Children Living in Household

Are there any changes since your last appointment regarding children still living or not living in the home? Yes _____ No _____ If yes, what are the changes?

_____

_____

HEALTH INFORMATION

How would you rate your health? _____

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

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

_____

_____

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 since your last appointment.

_____

_____

Are you currently self medicating? Yes _____ No _____

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

_____

List any special needs you have. _____

_____

List medical conditions or situations that have been discovered since your last appointment: _____

_____

Have you had or been involved with an abortion since your last appointment?

Yes _____ No _____. If yes, what was your involvement? _____

_____

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

Other related issues: _____

PERSONAL CONCERNS (that brings you back 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? _____

_____

_____

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				
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 feel depressed.	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				
I feel no emotions.	0 …. 1 …. 2 …. 3 …. 4 …. 5 …. 6 ….. 7…. 8 …. 9 ….10				
I have considered suicide.	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				
My emotions are out of control.	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 have suffered recent loss.	0 …. 1 …. 2 …. 3 …. 4 …. 5 …. 6 ….. 7…. 8 …. 9 ….10				

	Never	Rarely	Occasionally	Often	Constantly
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 have attempted suicide.	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				
I hate myself.	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 self-mutilate.	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 list any new physical, emotional, or spiritual symptoms that you have noticed or cause concern. _____

_____

_____

Please give examples of how the symptoms that you listed 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 since your last appointment? _____

_____

_____

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 been arrested since your last appointment? Yes _____ No _____ . If so, what was the charge? _____

_____

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 _____

Cell Phone _____ Work Phone _____

Secondary contact person:

Name _____

Relationship to you _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

Thank you for choosing us to serve you again. We appreciate the continued trust that you have shown to us.