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
_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse

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

EDUCATION

Did <u>you</u> graduate high school? Yes _____ No _____ GED? _____

If so, where? _____

If not, why not? _____

If not, what was the highest grade achieved? _____

Did <u>you</u> 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 needs you have. _____

_____

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

___ Cancer	___ Diabetes	___ Gall bladder disease
___ Thyroid Disease	___ Emphysema	___ Blood born infection
___ High blood pressure	___ Alcoholism	___ Schizophrenia
___ ADHD	___ Stroke	___ Physical abuse
___ Hypertension	___ Ulcers	___ Heart Disease
___ Glaucoma	___Depression	___ Bipolar Illness
___ Sexual Abuse	___ Dyslexia	___ 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.

___ Aggression	___Sexual Difficulties	___ Money Issues/Problems
___ Alcohol Dependence	___ Sick Often	___ Anger
___ Heart Palpitations	___ Antisocial Behavior	___ Speech Problems
___ Infidelity	___ Suicidal Thoughts	___ Impulsivity
___ Trembling	___ Judgment Errors	___ Withdrawing
___ Disorientation	___Loneliness	___ Distractibility
___ Memory Impairment	___ Dizziness	___ Mood Shifts
___ Drug Dependence	___ Panic Attacks	___ Problems Concentrating

___ Headaches
___ Recurring Thoughts
___ Appetite Changes
___ Difficulty Keeping Job
___ Eating Disorder
___ Tremors
___ Stressed Out
___ Nightmares
___ Elevated Mood
___ Guilt
___ Over-Ambitious
___ Bedwetting

Fears

___ Phobias
___ Hysterical Reactions
___ Delusions/Illusions
___ Avoiding People
___ Obsessive Compulsive Habits
___ Disorganized Thoughts
___ Voices in My Head
___ Hallucinations
___ Disorientation
___ Worrying

Stress/Depression

___ Coping Difficulty
___ Burnout
___ Chest Pain
___ Sleeping Problems
___ Stomach Problems
___ Hopelessness
___ Shame
___ Physical Symptoms of Stress
___ Fatigue
___ Irritability
___ High Blood Pressure
___ Feeling Sad
___ Helplessness
___ Difficulty Making Decisions
___ Inability to Adapt
___ Anxiety
___ Depression
___ Gloomy
___ Loss of Interest
___ Crying/Tearful
___ 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.