CLIENT INTAKE FORM

Directions: Please answer all items. If an item does not apply to you, simply write "N/A".

Name: _____ **Today's Date:** _____

Social Security: _____ **Date of Birth:** _____ **Age:** _____ **Gender:** _____

Sexual Orientation (✓): Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Other ☐

Race & Ethnicity (Cultural Background): _____

Full Address: _____

Phone Number: _____ **Email:** _____

Occupation: _____ **Highest Level of Education:** _____

Relationship Status: _____

Preferred Method of Contact (✓): Telephone ☐ Text Message ☐ Email ☐

Name of Insurance: PLEASE LEAVE BLANK **Insurance Policy Number:** PLEASE LEAVE BLANK

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship to Emergency Contact: _____

Type of Counseling Desired (✓): Individual ☐ Couple ☐ Family ☐ Group ☐

Describe your relationship with your family of origin (i.e., your parents, siblings, etc.):

Describe your relationship with your spouse/romantic partner:

Describe your relationship with your children and/or any minors you consistently care for (e.g., grandchild, niece/nephew, foster child, etc.):

Describe your faith journey/relationship with God:

List the faith disciplines you want to incorporate in counseling (e.g., prayer, Bible reading, meditation, etc.):

List the activities you enjoy during your free time:

Is there anyone in your family diagnosed with, treated for, and/or personally experienced any of the following (✓):

	YES	NO		YES	NO
Bipolar Disorder	☐	☐	Homicide	☐	☐
Depression	☐	☐	Domestic Violence	☐	☐
Anxiety	☐	☐	Post-Traumatic Stress Disorder	☐	☐
Anger/Rage	☐	☐	Schizophrenia	☐	☐
Suicide	☐	☐			

If you answered YES in the above section, which family member(s) had/has the diagnosis or experience?

Please list any physical or behavioral health issues you have (e.g., diabetes, cancer, Tourette Syndrome, etc.):

Please describe your reason(s) for seeking counseling services:

Directions: Below is a Common Signs of Distress list. Place an "X" next to the sign(s) of distress you are currently experiencing or recently experienced (i.e., within the last 3 months).

Common Signs of Distress	Place "X" Here
Frequent feelings of sadness, hopelessness, depression, etc.	
Frequent feelings of anger, irritation, frustration, etc.	
Loss of motivation	
Inability to focus on important tasks (at home, school, work, church, etc.)	
Sleeping too little or too much	
Eating too little or too much	
Increased tension and/or dissatisfaction within relationships (e.g., friends, family members, co-workers, romantic partners)	
Physical pain (e.g., headaches, stomach aches)	
Frequent illnesses (e.g., cold, flu)	
Fatigue/Tiredness	
Decreased sex drive	
Increased sex drive	
Overwhelmed	
Excessive worrying or anxiousness	
Withdrawing from social relationships (e.g., friends, family, co-workers, romantic partners)	
Poor attendance and/or performance (at home, work, school, church)	

Use of alcohol and other drugs to help me feel better	
Thoughts of wanting to kill someone (homicide)*	
Thoughts of wanting to kill yourself (suicide)**	
Other Signs Not Mentioned:	

***Thoughts of homicide, especially with a plan, is reportable by law. The counselor will discuss this further with you.**

****Calling the Suicide Prevention Hotline 1-800-273-TALK (8255) may be helpful if <u>currently</u> having thoughts of suicide. The counselor will discuss this and other resources of assistance with you.**

Directions: Please answer the questions below with either a "Yes" or "No" in the right column. When applicable, type in your response after the word "ANSWER" in the space provided. <u>Do not</u> write in the gray boxes.

Client Questions	Yes/No
1. Have you ever experienced intimate partner violence/domestic violence of any kind (e.g., verbal abuse, emotional abuse, physical abuse, sexual abuse, financial abuse, etc.)?	
a. If yes, by whom? Example: girlfriend, boyfriend, wife, husband, my child, friend, etc. **<u>ANSWER:</u>**	
b. Is the abuse still happening?	
2. As a child, did you ever experience any kind of sexual abuse (e.g., molestation, forced to sexually touch or perform sexual acts on yourself or someone else, rape, etc.)?	
a. If yes, by whom? Example: family member, friend, stranger, etc. **<u>ANSWER:</u>**	
b. Is the abuse still happening?	
3. As an adult, have you ever experienced any kind of sexual abuse (e.g., sexually touched by someone else when you didn't want to be touched, forced to sexually touch or perform sexual acts on yourself or someone else, rape, etc.)?	
a. If yes, by whom? Example: family member, romantic partner, friend, stranger, etc. **<u>ANSWER:</u>**	
b. Is the abuse still happening?	

4. Have you ever engaged in sexual acts in exchange for something of value (e.g., food, money, clothes, shoes, a place to live, etc.)?	
5. Have you ever received mental health counseling before?	
6. Have you ever received a mental health diagnosis?	
a. If yes, what was it? **ANSWER:**	
7. Have you ever taken medications for a mental health or emotional issue?	
a. If yes, which medication(s)? **ANSWER:**	
8. Have you ever been hospitalized for mental health or emotional reasons?	
a. If yes, when, where, and for how long? **ANSWER:**	
9. Are you pregnant (for women only)?	
10. What drugs (e.g., alcohol, marijuana, crystal methamphetamine, cocaine, crack, Xanax, mollies, ecstasy, heroin, Adderall, Ritalin etc.) have you taken in the past (i.e., over 1 year ago)? **ANSWER:**	
11. What drugs (e.g., alcohol, marijuana, crystal methamphetamine, cocaine, crack, Xanax, mollies, ecstasy, heroin, Adderall, Ritalin etc.) are you taking currently or took recently (i.e., less than 1 year ago)? **ANSWER:**	
12. Do you have any legal issues (e.g., probation, restraining order, civil case, criminal case, immigration, etc.)?	
13. Have you ever had thoughts of harming or killing yourself?	
14. Have you ever had thoughts of harming or killing someone else?	
15. Have you ever done anything harmful to yourself (e.g., taking pills, cutting the body with a sharp object, pulling trigger of loaded gun, etc.) because you wanted to die?	

16. Have you ever done anything harmful to yourself (e.g., taking pills, cutting the body with a sharp object, pulling trigger of loaded gun, etc.) because you wanted the pain, anger, etc. to go away?	
17. Have you ever done anything harmful to yourself (e.g., taking pills, cutting the body with a sharp object, pulling trigger of loaded gun, etc.) because you wanted to get the attention of someone who you felt was not paying attention to you?	
18. Are you currently having thoughts of harming or killing someone?*	
19. Are you currently having thoughts of harming or killing yourself?**	

***Thoughts of homicide, especially with a plan, is reportable by law. The counselor will discuss this further with you.**

****** **Calling the Suicide Prevention Hotline 1-800-273-TALK (8255) may be helpful if currently having thoughts of suicide. The counselor will discuss this and other sources of assistance with you.**