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INTAKE INFORMATION

DATE: _____ CLIENT ID#_____
NAME:_____
ADDRESS:_____ CITY:_____ ZIP: _____
HOME PHONE:_____ WORK PHONE: _____
DATE OF BIRTH:_____ AGE: _____ SEX:_____ SS#: _____
RACE: _____ RELIGIOUS AFFILIATION: _____ PRACTICING: YES NO
REFERRED BY: Church _____, newspaper _____, friend: _____
EMPLOYMENT STATUS: Employed Unemployed Retired Student Homemaker Disabled
MARITAL STATUS: Married Divorced Separated Single Live-in partner Widow/widower
LIVING ARRANGEMENTS: Spouse Partner Parent Parents Single Family Friends

NAME OF SPOUSE OR SIGNIFICANT OTHER:_____
PREVIOUS MARRIAGES: 1._____ When _____
2._____ When _____
HOW MARRIAGE ENDED: 1._____ When _____
2._____ When _____

CHILDREN'S NAMES	DOB	AGE	RESIDING WITH
1.			
2.			
3.			
4.			
5.			
6.			

EMPLOYER/SCHOOL	CITY	POSITION/GRADE
1.		
2.		

PRESENTING PROBLEM: _____
_____
_____
_____
_____
_____

FAMILY OF ORIGIN INFORMATION

Where were you born: _____

Are you adopted: _____

Mother's name: _____ What kind of work did she do? _____

Father's name: _____ What kind of work did he do? _____

Did your parents divorce: _____ If yes, did they remarry? _____

Stepfather's name: _____ Stepmother's name? _____

_____ _____

Siblings: (indicate whether full, half, or step)

NAME	RELATIONSHIP	AGE	DOB
1.			
2.			
3.			
4.			
5.			
6.			

Is there a family history of: (Use additional space if necessary)

_____ Alcoholism Who _____

_____ Drug Abuse Who _____

_____ Mental Illness Who _____

_____ Physical Abuse Who _____

_____ Sexual Abuse Who _____

_____ Verbal Abuse Who _____

_____ Arrests Who _____

_____ Suicide Who _____

_____ Suicide Attempts Who _____

_____ Epilepsy Who _____

_____ Tourettes Who _____

_____ Mental Retardation Who _____

_____ Heart Attacks Who _____

_____ High Blood Pressure Who _____

_____ Ulcers Who _____

_____ Diabetes Who _____

_____ Cancer Who _____

_____ Violent Temper Who _____

_____ Psychiatric Treatment Who _____

_____ Homicide Who _____

_____ Foster Care Who _____

DEVELOPMENTAL HISTORY

A. Birth: Were you premature _____

Complications during pregnancy or delivery _____

B. Neonatal: Baby went home with mother _____

Feeding/behavior problems _____

Birth defects _____

Early separation from parent _____

Rate of development: Walk _____ Talk _____ Toilet trained _____

C. Childhood: Medications _____

Health Problems _____

School Problems _____

Learning Disabilities/Hyperactivity _____

Losses _____

Accidents _____

Firesetting/Cruelty to animals _____

D. Teen School Problems _____

Truancy _____

Jobs _____

First Date _____

First Drove car _____

First sexual experience _____

Sexual acting out _____

Problems with Dad _____

Problems with Mom _____

Problems with the Law _____

First tried Alcohol _____

Problems with Alcohol _____

Problems with Drugs _____

Violence/Aggression _____

Poor Impulse Control _____

SEXUAL ISSUES (Include sexual activity, sexual orientation, use of birth control, sexual abuse, incest, rape, and sexual dysfunction. Risk factors for HIV) _____

_____

_____

_____

PRIOR COUNSELING OR PSYCHIATRIC TREATMENT:

Recent Outpatient: Y N Therapist _____ When _____

Prior Outpatient: Y N Therapist _____ When _____

Prior Inpatient: Y N Facility _____ When _____

PSYCHIATRIC MEDICATIONS: _____

SUBSTANCE USE HISTORY

Have you ever abused drugs or alcohol? Y N

If yes, please describe:

Substance	Amount	Frequency	When (First use; last use)

Has there been substance abuse *treatment* of any kind? Y N

Is there a history of blackouts, seizures, or withdrawal symptoms? Y N

MEDICAL HISTORY

Previous illness history: _____

Current physical symptoms: _____

Family illnesses (serious): _____

Allergies: _____

Menstrual history: _____

Other: _____

ASSESSMENT OF IMPACT ON LIFE ROLES

Indicate how much your current problem(s) has affected the following:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not applicable
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Finances	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Weight Change (in pounds):	Gained:		Lost:			
Sleeping Habits:	1	2	3	4	5	N/A
Insomnia:	Early		Middle		Late	
Sexual Functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

COUNSELING PROCESS

If you were in counseling previously, what issue(s) did you address? _____

If you were in counseling previously, what did you consider to be most helpful? _____

What are your expectations for counseling? _____

Have you had this problem (or this type of problem) before? When? _____

What helped you deal with is then? _____

How can you tell when you are angry? sad? frustrated? _____

How do you get rid of these unpleasant feelings? _____

What happens when this doesn't work? _____

Other information you feel the counselor should know? _____