CLIENT INFORMATION INTAKE FORM

THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL

(PLEASE PRINT CLEARLY)

Today's Date: _____

Name: _____Birthdate_____Age_____

Address_____

City_____ State_____ Zip_____ Email Address:_____

Home Phone_____Work Phone_____ _____

Can we leave a message? Yes No Best Place to Leave a Message _____

Who were you referred by? _____

Level of Education: HS___ College____ Other___ Place/Type of Employment_____

How long? _____ If unemployed, how long: _____ what type of work did you do? _____

Marital Status (Parents if for a child) married____# of years____; divorced___# of years ___;

widowed____# of years____; single____; living with_____

Spouse's Name_____Spouse's Occupation_____

CHILDREN (SIBLINGS IF FOR A TEEN)

NAME	BIRTHDATE	GENDER

In Case of Emergency Notify: _____ Phone: _____

Relationship:_____

Have you ever been hospitalized for psychiatric reasons? Y N If yes, what were the circumstances? Please include dates: _____

When was your last full physical exam? _____

Any physical issues? _____

Sleeping issues? Y N How many hours of sleep to you get each evening? _____

List any medications you are presently taking and dosage: _____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc)

_____

_____ Any problems with Alcohol?_____drugs?_____

Do you have current thoughts of suicide? Yes No If so, do you have a plan? Yes No

Have you *ever* had thoughts about suicide Yes No

Have you ever attempted suicide? Yes No If yes, how many times? _____

How do you spend time relaxing? _____

Have you ever had concern about eating habits? Yes No

Reasons for seeking counseling at this time? _____

_____

_____

Have you ever been in counseling before? Y N For how long? _____

Was it helpful? Y N Please explain: _____

Is this your choice for counseling? (if no, please explain) _____

_____

Please Check Any of the Following Conditions That Currently Apply to You

___Headaches	___Nervousness	___Dizziness	___Fainting Spells
___Shyness	___Stomach Trouble	___Relaxation	___Stress
___Anxiety	___Fatigue	___Legal Matters	___Self Control
___No Appetite	___Anger	___Memory	___Making Decisions
___Insomnia	___Nightmares	___Separation	___Energy
___Inferiority	___Take Sedatives	___Drug Use	___Loneliness
___Bowel Troubles	___Marriage	___Use Alcohol	___Allergies
___Suicidal	___Sexual Problems	___Work	___Under eating
___Overeating	___Home Conditions	___Friends	___Concentration
___Temper	___Ambition	___Divorce	___My Thoughts
___Parenthood	___Health Problems	___Age	___Finances
___My appearance	___Future	___Sexual Abuse	___ Children
___Career Choices	___Weight	___Unhappiness	___Depression
___Mood Swings	_____Fears	___Self-esteem	___Physical Abuse

Circle everything that has happened to you in the past two years:

Death of a spouse/partner Marriage Problems Divorce

Death of a family member Family Issues (with children/parents/in-laws)

Major illness/injury of self Financial issues Move to another city or state

Major illness/injury of relative Legal Problems Bad break up

Job dissatisfaction Loss of job Other _____

Religious/Spiritual/ Faith Information:

How often do you attend Church, Synagogue or other religious services?_____

If so, where do you attend?_____

Describe any specific religious/spiritual beliefs/values you feel strongly about _____

_____

Consent for evaluation and treatment. –

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: _____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor: _____ DOB _____

Relationship: _____