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Client Intake Form

Name_____ Age_____ Date of Birth_____

Address_____City_____

Cell Phone_____ is it okay to leave a message? Y / N

Preferred way to contact you? _____

How did you hear about my services: _____

Primary Care Therapist: _____

Name of Employer _____

Gender Identification _____Sexual Orientation_____ Sexually Active Y / N

Race / Ethnicity_____

Relationship Status ___Single ___Married ___Partnered ___ Separated ___Divorced ___Widowed

Who are the people you live with? Please provide names, age, and relationship.

Name Relationship Age How would you describe the relationship?

_____

_____

_____

_____

Mental Health Information

Have you ever had counseling before? Y / N If yes, briefly describe the reason, the therapists name, approximate dates and whether the counseling was helpful.

_____

_____

Briefly describe what brings you to here today?

_____

_____

What goals would you like to achieve from our work together?

_____

_____

Medication Information:

Name of Medication Dosage Date Started Prescribing Physician

_____

_____

_____

Please check any of the following issues that are a concern for you:

	Recovery Support		School or Work Issues		Grief / Loss
	Drug or Alcohol Abuse		Relationship Issues		Anger
	Parent Support/Coaching		Preoccupation w/ use		Attempts to stop use
	Blackouts		Excessive Screen Time		Depression
	Stress		Self Esteem		Anxiety
	Guilt/Shame		Use to deal w/feelings		Solitary Use
	Use despite Consequences		Binge Use		Loss of Control
	Daily Substance Use		Concern expressed by others		Drug Seeking Behavior

Have you ever attempted suicide? Y / N If yes, please describe further:

Date Prompting Event Means of Attempt (How) Hospitalized?

_____

_____

When was the last time you had thoughts of suicide? _____

Did you have a plan? Y / N If yes, please describe: _____

Have you had any self-harming incidents in the last three months? Y / N Last time? _____

Have you ever been hospitalized or gone to the emergency room? Y / N If yes, please describe:

Date(s) of Hospitalization What Facility Reason for Hospitalization

_____

_____

Please List any mental health diagnosis you have received in the past:

Diagnosis Date of Diagnosis Who made this Diagnosis?

_____

_____

Who in your immediate family has experienced the following?

M (mom) **D** (dad) **S** (sibling) **GP** (Grandparent)

	Drug / Alcohol Abuse		Prescription Drug Abuse		Disordered Eating
	Depression / Anxiety		Suicide Attempts		Mental Health Issues
	Mood Swings		Self-Harming Behavior		Anger Problems

Have you ever experienced any traumas or losses in your life? Y / N If yes, please describe briefly:

_____

_____

Who do you turn to for support?_____

Major Disabilities or Limitations:

	ADD/ADHD		Vision		Hearing
	Learning		Autism Spectrum		Speech
	Developmental		Physical		Other:

Substance Use History: Have you **ever** used/abused the following?

		How Often	How Much	Date of Late Use
	Alcohol			
	Marijuana / Dabs			
	Cocaine / Crack / Meth			
	Prescription Pain Meds			
	Xanax/Klonopin/Ambien			
	Heroin / Opioids			
	Hallucinogens			
	Ecstasy / Molly / 2CB			
	Any Club Drugs / GHB			
	Spice / Bath Salts			
	DXM / Triple C			
	Ritalin / Adderall (abuse)			
	Nicotine			
	Energy Drinks			
	Vaporizing any substance			

Most alcohol used in one setting: _____ when: _____

Have you ever experienced any consequences (Family, Physical, Legal, Work, School) due to your use? Y / N

_____

Have you ever had drug / alcohol counseling or treatment? Y / N If yes, when and where?

_____

Has anyone ever thought you had a problem with substances? Y / N Who? _____

*****Emergency Contact Numbers*****

Name: _____ Relationship_____ Phone_____

Name: _____Relationship_____Phone_____

Please be advised that this intake form is for information gathering purposes only. It will not be used to make a diagnosis nor shall it be used in place of treatment or therapy. Any advice, consulting or skills training provided is designed to serve as adjunct support augmenting ongoing services of licensed professionals.