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Client Intake Form – Adult

*Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.*

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Identified Gender _____ Gender/Preferred Pronouns _____

Address _____

Contact Phone Number(s) Cell _____ Other _____

Contact E-Mail Address _____

Status: Single Married Partnered Divorced Widowed Other

Number of children _____

Names and Ages of children _____

Occupation _____ Employer _____

Ethnicity _____ Religion _____

Emergency Contact Information

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Client Health History

Are you currently working with a physician, psychiatrist, or other healthcare provider?

YES NO

Physician Name & Practice Name _____

Would you like me to coordinate with this provider? YES NO

History of Mental Health Services: _____

History of Psychiatric medication YES NO

List: _____

Previous Mental Health diagnosis YES NO

List: _____

Current Medications YES NO

List: _____

Relevant Medical Diagnosis: _____

History of substance use/abuse? YES NO Current? YES NO

Are others concerned about the amount of alcohol you drink / your recreational drug use?

YES NO

Generally, how do you sleep? Check all that apply:

Great! OK Hard to fall asleep Hard to wake up Wake up frequently at night

Generally, how often are you active (exercise, play, garden, etc.)? Check all that apply:

Hardly ever 1x per week 2-3 times per week 4x or more per week Daily

Have you ever been hospitalized for psychiatric reasons? YES NO

If yes, when? _____

Have you ever made a plan to commit suicide or attempted suicide? YES NO

If yes, when? _____

Do you currently have thoughts of ending your life, or acting recklessly in a way that would kill you? YES NO

Please list any additional information you would like me to know:

Please check following symptoms or issues that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Decision Making |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Financial Stress |
| <input type="checkbox"/> Drug/Alcohol Use | <input type="checkbox"/> Anger | <input type="checkbox"/> Worry/Fear |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Abuse | <input type="checkbox"/> Strained Relationship(s) |
| <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Cutting/Self-Harm | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Health Concern | <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Grief and Loss |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Trauma | <input type="checkbox"/> Divorce/Separation |
| <input type="checkbox"/> Focus/Attention | <input type="checkbox"/> Lack of Motivation | |

Other: _____

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
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To what degree do your problems affect your ability to perform at work, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
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When did these problems begin, and what was happening in your life at that time?

Client Interest in Counseling Services

Please describe what brings you to counseling:

What are your goals for counseling?

How motivated do you feel to work on your goals? Do you have concerns about counseling or working on these issues?

Please list your current hobbies:

What do you consider to be your strengths?

Form completed by: _____ Date: _____

Signature: _____