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INTAKE INFORMATION PACKET

Today's Date: _____
Client's Name: _____
Parent or Guardian's Name (if client is a minor): _____
Address: _____City: _____State:_____Zip:_____
Primary Phone: _____Is it ok to leave a message? ☐ Yes ☐ No
Client Age: _____Date of Birth: _____ ☐ Male ☐ Female
Employer: _____
Occupation: _____

Why are you seeking Counseling:
_____
_____
_____
Approximately, how long have you had the current concern? _____
In what way have you attempted to cope with this concern? _____
_____
How were you referred? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?
Insured: _____
Relationship to client: _____
Address: _____City: _____State: _____Zip:_____
Insured Date of Birth: _____
Insurance Carrier: _____ Member ID #: _____
Your payment is to be paid in full at the time of each session. Currently, I only accept cash or check, NO credit or debit cards please.

Please check the boxes next to the most significant issue(s)

Issues Related To Abuse
- ○ Current or past physical abuse
- ○ Current or past sexual abuse
- ○ Current or past history of emotional abuse
- ○ Current or past neglect
- ○ History of abandonment
- ○ Suspected child abuse
- ○ History of domestic violence

Mood Related Concerns
- ○ Disturbing memories
- ○ Difficulty sleeping
- ○ Nightmares
- ○ Suicidal thinking
- ○ Irritability

Academic/School Issues
- ○ Learning difficulties
- ○ Problems with peers
- ○ Problems with teachers
- ○ Failing grades
- ○ Refusing to go to school
- ○ Bullying concerns
- ○ Friend or peer concerns

Family Concerns
- ○ Difficulty adjusting to family changes
- ○ Discipline concerns
- ○ Parent-child relationship concerns
- ○ Sibling concerns
- ○ Divorce/separation

- Sadness/Depression
- Feelings of guilt/shame
- Excessive worrying or fear
- Low self-esteem, shyness, problems making friends
- Feeling down, blue, or irritable
- Fatigue, low energy

- Other marital problems
- Constant fighting

Behavior Issues

- Aggression towards others
- Drug/alcohol use
- Truancy
- Gang involvement
- Running away
- Stealing
- Fire-setting

Other Concerns

- Sexual identity concerns
- Inappropriate sexual behavior
- Overeating/refusal to eat
- Hyperactivity/impulsivity
- Lying
- Self-injurious behaviors
- Stress management concerns
- Financial problems
- Work related stress
- Legal Problems

When did you first become concerned about the main/most significant concerns? _____

_____

_____

Why, at this point, have you decided to pursue counseling? _____

_____

_____

GENERAL OVERVIEW

Have you been involved with counseling previously? ☐ Yes ☐ No Approximate Dates: _____

Current living arrangements: ☐ Family of origin ☐ Single ☐ Spouse/Partner ☐ Roomate ☐ Other

Marital history/status: ☐ Never married ☐ currently married ☐ Divorced ☐ Widow

Are you currently on probation/parole? ☐ Yes ☐ No

If yes, please explain: _____

_____

PHYSICAL AND MENTAL HEALTH HISTORY

Primary care physician (name and contact information):_____

_____

Physical disability: ☐ Yes ☐ No (if yes please explain) _____

_____

Chronic illness ☐ Yes ☐ No (if yes please explain) _____

_____

Terminal illness ☐ Yes ☐ No (if yes please explain) _____

_____

Are you currently seeing a psychiatrist? ☐ Yes ☐ No

What medications are you currently taking (if any)? _____

_____

_____

Any history of behavioral/conduct problems? ☐ Yes ☐ No
If yes, Please explain
_____
_____

Any history of emotional/mental health related issues? ☐ Yes ☐ No
If yes, Please explain
_____
_____

Any history of Inpatient psychiatric care? ☐ Yes ☐ No
If yes, Please explain
_____
_____

Any history of suicide attempts? ☐ Yes ☐ No
If yes, Please explain
_____
_____

Any history of addictions (substance, gambling, computer, sex)? ☐ Yes ☐ No
If yes, Please explain
_____
_____

Any history of family violence? ☐ Yes ☐ No
If yes, Please explain
_____
_____