

# Client Intake Form

Today's Date \_\_\_\_\_

A. Client's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Parent/Guardian's name(s) \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_

street city state zip

Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Best time to call \_\_\_\_\_

Marital Statue: single engaged  
married (how long \_\_\_\_\_; times married \_\_\_\_\_)  
separated (how long \_\_\_\_\_) divorced (how long \_\_\_\_\_)

Education \_\_\_\_\_ Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Spouse's education \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

B. List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

C. Who is coming for counseling? \_\_\_\_\_ Any prior counseling  
If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_ With whom? \_\_\_\_\_  
Why? \_\_\_\_\_

Are you, or another family member, currently seeing a psychiatrist or another counselor?

Yes No

If so, what family member? \_\_\_\_\_ Name of helper \_\_\_\_\_

For what purpose? \_\_\_\_\_

Person to contact in emergency (name, relationship, phone, address) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE FILL OUT THE FOLOWING INFORMATION  
AS IT APPLIES TO THE CLIENT**

D. State the nature of the problem in your own words: \_\_\_\_\_  
 \_\_\_\_\_

What is your most difficult relationship right now? \_\_\_\_\_

What is your most difficult emotion right now? \_\_\_\_\_

E. CRISIS INFORMATION: Any current suicidal thoughts, feelings, or actions?  
 Yes No If yes explain: \_\_\_\_\_

Any current homicidal or assaultive thoughts, or feelings, or anger-control problems?  
 Yes No If yes explain: \_\_\_\_\_

Any past problems, hospitalizations, or incarcerations for suicidal or assaultive behavior?  
 Yes No If yes, describe: \_\_\_\_\_

Any current threat of significant loss or harm (illness, divorce, custody, job loss, etc.)?  
 Yes No If yes, describe: \_\_\_\_\_

F. MEDICAL INFORMATION: Doctor's name, address, and phone \_\_\_\_\_  
 \_\_\_\_\_

Are you presently taking any medication? Yes No If so, what? \_\_\_\_\_

For what purpose? \_\_\_\_\_

Any problems with eating sleeping chronic pain recent weight changes

Describe any answers checked above: \_\_\_\_\_

Any other medical problems? \_\_\_\_\_

Have you or a family member ever been hospitalized for mental or emotional illness?  
 Yes No If yes, please explain – dates, place, reason: \_\_\_\_\_

G. Common problem/symptom checklist. Fill in: 0=none 1=mild 2=moderate 3=severe

\_\_\_ marriage \_\_\_ divorce/separation \_\_\_ alcohol/drugs \_\_\_ God/faith

\_\_\_ premarital \_\_\_ child custody \_\_\_ other addictions \_\_\_ church/ministry

\_\_\_ singleness \_\_\_ disabled \_\_\_ grief/loss \_\_\_ past hurts

\_\_\_ sexual issues \_\_\_ work/career \_\_\_ depression \_\_\_ codependency

\_\_\_ family \_\_\_ school/learning \_\_\_ fear/anxiety \_\_\_ intimacy

\_\_\_ children \_\_\_ money/budgeting \_\_\_ anger/control \_\_\_ communication

\_\_\_ parents \_\_\_ aging/dependency \_\_\_ loneliness \_\_\_ self-esteem

\_\_\_ in-laws \_\_\_ weight control \_\_\_ mood swings \_\_\_ stress management

Other (specify): \_\_\_\_\_

H. Who referred you to us? (name, relationship, and phone number) \_\_\_\_\_  
 \_\_\_\_\_

If a professional referred you to us, may we send them a thank you noting your contact?

Yes No

If yes, we will only send a thank you. Any other contact will require your express written permission.