Date \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

**Client Intake Form**

**I.CLIENT INFORMATION**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_

Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we leave a message? \_\_\_Yes \_\_\_No

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. PSYCHOSOCIAL HISTORY**

Educational History

Education (Check all that apply) \_\_\_ GED \_\_\_ HS Grad \_\_\_ College \_\_\_ None

Degree/Major\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vocational Training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of learning difficulties? \_\_\_\_\_Yes \_\_\_\_\_ No

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any barriers to learning, such as the inability to read or write? \_\_\_\_ Yes \_\_\_\_ No

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any special communication needs? \_\_\_\_ Yes \_\_\_\_ No

**Employment History**

Employed: \_\_\_\_Not employed \_\_\_\_Full time \_\_\_ Part time \_\_\_ Unemployed (Date last worked \_\_/\_\_)

Not in labor force: \_\_ Disabled \_\_Retired \_\_ homemaker \_\_Student \_\_Living in Institution \_\_\_Other

If employed, employer name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under financial distress? \_\_\_\_Yes \_\_\_\_ No

**Military History**

Are you now or have you ever been a member of the military? \_\_\_ Yes \_\_\_NoIf yes, what branch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any pertinent duties or trauma experienced during your service\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Social History**

Marital Status: \_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_Separated \_\_\_\_\_Divorced \_\_\_Widowed \_\_\_Remarried \_\_\_ Cohabitating

What is your current living situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Household Members** | **Relationship** | **Age** | **Quality of Relationship** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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Is there a history of mental illness in your family? \_\_\_ Yes \_\_\_ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently or have you even been physically, mentally, sexually, or emotionally abused? \_\_\_Yes \_\_\_\_ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a history of alcohol or drug abuse in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe are your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Describe what type of support system you have\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Drug/Alcohol History**

Have you ever had a problem with drug/alcohol abuse? \_\_\_Yes \_\_\_No If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illegal drug use in the past 12 months \_\_\_Yes \_\_\_ No

Prescription drug abuse in the past 12 months \_\_\_Yes \_\_\_No

Non-prescription drug abuse in the past 12 months \_\_\_ Yes \_\_\_ No

Alcohol use in the past 12 months \_\_\_Yes \_\_\_ No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug/Substance/Alcohol** | **Age of 1st use** | **Date of last use** | **Frequency** | **Amount**  | **Method** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**III. COUSNELING HISTORY**

Have you previously received counseling services? \_\_\_Yes \_\_\_\_No If yes, respond to all the items below.

Name of Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Facility (City and State)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Facility \_\_\_\_ Outpatient \_\_\_\_Inpatient (hospital)

Type of Counseling (Check all that apply): \_\_\_ Psychological \_\_\_ Substance Abuse

Date of Counseling: Start\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Problem(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Success in resolving previous problems (Check one) \_\_\_\_ Unsuccessful \_\_\_Partially Successful \_\_\_Highly Successful

What did you find to be particularly helpful or non-helpful about your previous counseling experience?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Were you prescribed any medication for dealing with the above issues? \_\_\_\_ Yes \_\_\_\_\_No If yes, what medication were you prescribed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. MEDICAL HISTORY**

Name of current physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of psychiatrist, if one is seen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all current and previous medical conditions from the list below

\_\_\_Problems with Vision/Hearing \_\_\_Headaches

\_\_\_Thyroid Problems \_\_\_Dizziness

\_\_\_Lung Disease \_\_\_Chest Pains

\_\_\_Stomach Problems \_\_\_Joint Pain

\_\_\_High Blood Pressure \_\_\_Diabetes

\_\_\_Heart Disease \_\_\_Seizures

\_\_\_Weight Loss \_\_\_Weight Gain

Physical exercise: times per week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for how long\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Pain (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Environmental Allergies (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Food Allergies (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other (Explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you *currently* take prescriptions or “over-the-counter” medication? \_\_\_Yes \_\_\_No If yes, please provide all requested information below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dosage** | **Times/Day** | **Start Date** | **Side Effects** |
|  |  |  |  |  |
|  |  |  |  |  |
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Do you currently take vitamins or herbal supplements? \_\_\_Yes \_\_\_No If yes, please provide all of the requested information below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Supplement** | **Dosage** | **Times/Day** | **Start Date** | **Side Effects** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**V. PRESENTING PROBLEM**

What problem(s) brings you to counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How long have you experienced this problem (Specify): \_\_Days \_\_Weeks \_\_Months \_\_Years

How often do you experience this problem? (Check one): \_\_Hourly \_\_Daily \_\_Weekly \_\_Other

How intense is this problem? (Check one): \_\_Mild \_\_Moderate \_\_Severe

**THE FOLLOWING IS TO BE FILLED OUT BY THE COUNSELOR AFTER THE SESSION**

**VI. MENTAL STATUS AND BEHAVIORAL OBSERVATIONS**

**A. Appearance** (note distinguishing physical characteristics, grooming, hygiene, etc):

\_\_Well dressed/groomed \_\_\_Adequately dressed/groomed \_\_\_Poorly dressed/groomed

**B. Behavior** (note particularly rapport and interaction with interviewer):

\_\_\_ Calm, no excesses or deficits \_\_\_ Poor eye contact

\_\_\_ Displays psychomotor agitation \_\_\_ Shows difficulties of impulse control

\_\_\_ Displays psychomotor retardation \_\_\_ Reluctant or guarded in interview

\_\_\_ Poor posture, balance, or coordination \_\_\_ Shows abnormalities of gait, limb usage

**C. Speech** (note rate, volume, coherence, abnormalities or deficits, etc):

\_\_\_ Fluent, no abnormalities or deficits

**D. Emotion**

1. Mood:

\_\_\_ Normal/Euthymic \_\_\_ Irritable \_\_\_ Elevated (mild)

\_\_\_ Depressed/Sad \_\_\_ Angry \_\_\_ Euphoric (moderate)

\_\_\_ Anxious or Fearful \_\_\_ Pain (emotional) \_\_\_ Expansive (severe)

1. **Affect:**

\_\_\_ Appropriate/Euthymic \_\_\_ Broad \_\_\_ Labile \_\_\_\_ Constricted

\_\_\_ Animated (as in mania) \_\_\_ Flat \_\_\_ Blunted

1. **Mood and Affect are:**

\_\_\_\_Congruent \_\_\_\_ Incongruent

**E.** **Thought Processes and Content** (note irregularities of word usage, thought blocking, racing thoughts, flight of ideas, loose associations, delusional, or near delusional ideations, magical thinking, etc.):

\_\_\_\_ No irregularities reported or noted

**F. Perception** (note hallucinations, illusions, depersonalization, derealization, dissociative processes):

\_\_\_\_ No irregularities reported or noted

**G. Other** (notable difficulties of orientation, attention, memory, judgment, intelligence, insight, etc.)

**Attention/Concentration Judgment Intelligence Insight Memory**

\_\_ Intact \_\_Good \_\_Above Avg. \_\_ Good \_\_Intact

\_\_Distractible \_\_ Average \_\_Average \_\_ Fair \_\_Short-term deficit

\_\_ Impaired \_\_ Poor \_\_ Below Avg. \_\_ Poor \_\_ Long-term deficit

**VI. DSM-5 DIAGNOSTIC IMPRESSIONS:**

**VII. RECOMMENDATIONS:**

\_\_\_ Individual counseling or psychotherapy

With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Group counseling or psychotherapy

With what group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Outside referral

Whom or where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ No further services are recommended. And/or, Interviewee does not desire further assistance.

\_\_\_ Other recommendations:

**VIII. CLINICAL SUMMARY**

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

Counselor Signature Date