Confidential Client Intake Form

General Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Please **DO NOT** contact me at: ☐ Home ☐ Work ☐ Cell E-mail:_____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Employer: _____ Occupation/Title:_____

Years at job: _____ Highest level of education completed: _____

Do you have a church, synagogue or other religious affiliation? Yes ☐ No ☐

Place of Worship: _____

How did you hear about our services?_____

Relational Information

Marital status: **0** Single **0** Engaged **0** Married **0** Separated **0** Divorced **0** Widowed

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse: _____ Spouse's age: _____

Spouse's Occupation: _____

Please provide a brief description of your spouse (e.g., angry, controlling, outgoing, supportive): _____

_____

Please list your children, including step, adopted and foster children (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Abortions ☐ Gambling
☐ Drug/Alcohol Addiction ☐ Religious Upbringing ☐ Major Losses ☐ Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? ☐ Yes ☐ No

If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? ☐ Yes ☐ No

If yes, who and when: _____

Medical History

Name and Town of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues and Goals

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

Check any of the following symptoms or problems that you are currently or have recently experienced:

☐ Stress	☐ Grief	☐ Verbal abuse	☐ Impulsive behavior	☐ Anxiety
☐ Chronic pain	☐ Sexual abuse	☐ Controlling	☐ Sexual problems	☐ Fears
☐ Loneliness	☐ Sexual addiction	☐ Obsessive thoughts	☐ Depression	☐ Panic
☐ Indecisiveness	☐ Poor concentration	☐ Shyness	☐ Gender identity	☐ Anger
☐ Fatigue	☐ Low self-esteem	☐ Hearing voices	☐ Loss of appetite	☐ Bad dreams
☐ Marital problems	☐ Aggression	☐ Racing thoughts	☐ Trouble sleeping	☐ Apathy
☐ Relational issues	☐ Eating problems	☐ Physical Abuse	☐ Unwanted memories	☐ Alcohol use
☐ Feeling worthless	☐ Emotional Abuse	☐ Loss of control	☐ Pregnancy/Abortion	☐ Work issues
☐ Financial issues	☐ Spiritual apathy	☐ Drug use	☐ Career choices	☐ Loss
☐ Compulsive behavior		☐ Controlled by others	☐ Seeing things others don't	

Please place an "X" on the scale to indicate how distressing your problems are to you.

{----------}
Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No
Have you experienced suicidal thoughts or attempted suicide in the past? ☐ Yes ☐ No
Are you currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

We trust that your involvement with Life Counseling Center will be helpful to you. If you have any questions regarding any aspects of your relationship with us, please discuss them with your therapist or our office staff. My signature certifies that I have completed the Intake & thoroughly read, understand and agree to all the Policies & Procedures of Life Counseling Center listed on pages 7 & 8 of this packet.

_____ _____
Client's Signature Date