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Client Intake Packet

Name_____ Age_____ Birth date _____
Address_____ City_____
Zip_____
Occupation _____
Employer_____
Address _____
Home Phone ( ) _____ Work ( ) _____
Cell ( ) _____ Email address_____
Is it O.K. to call you at home? _____ at work? _____ by Cell? _____ by text message? _____
by email? _____ May I identify myself/leave message? _____ Initial approval _____
Reason(s) for seeking therapy?

_____

_____

_____

_____

Who referred you to me? _____
May I thank them? Yes No
Marital Status: (Circle) Single Married Divorce Widow Separated, How Long? _____
Previous Marriage(s)? _____
Previous Counseling? (Circle) Yes No When _____ Duration _____
Was it a good experience? _____
Have you ever been hospitalized for psychological treatment? _____ When? _____
Where_____
Are you currently under a physician's and/or psychiatrist's care? _____
M.D. & Phone _____
Date of Last Physical _____
Medications currently taking (use back of page if needed)

_____

_____

_____

_____

Please indicate your highest level of education:
Some High School_____ H.S. Diploma_____ Some College_____ College _____ Degree_____
Graduate Degree_____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name _____ Phone ( ) _____
Relationship _____

Client Questionnaire (cont)

SPOUSE/SIGNIFICANT OTHER INFORMATION:

Name_____ Age_____ Birthdate _____

Address (if different than above)

_____

Occupation _____

Employer _____

Address _____

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

CHILDREN:

Name _____ Birth date _____

Name _____ Birth date _____

Name _____ Birth date _____

Name _____ Birth date _____

Name _____ Birth date _____

Name _____ Birth date _____

OTHERS LIVING IN HOME:

_____

_____

_____

_____

Why are you here? Describe reasons for seeking help.

What help do you expect from therapy?

Is there anything from your past history that may be related to the difficulties you are having now? (trauma, abuse, substance use, learning difficulties etc....)

On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your problem(s)?

Client Questionnaire (cont)

Are you depressed at this time? Yes_____ No _____ Sometimes _____
How serious would you say your depression is? (Scale of 1-10) _____
Have you had any suicidal thoughts? Yes _____ No _____
Have you ever attempted suicide? Yes _____ No _____
Any history of suicide attempts in family members? Yes _____ No _____
Who?_____

_____

_____

Whom have you presently consulted about your present problems?

_____

_____

List your five worst fears: Worst fear first. 1)_____
2)_____ **3)**_____
4)_____ **5)**_____

What do you consider your strengths?

_____

_____

_____

_____

_____

Please check all of the following which are, or have been, problems for you:

__ Anxiety
__Shyness
__Tension
__Tremors
__Insomnia
__Dizziness
__Headaches
__Parenting
__Tiredness
__Alcohol use
__Drug use
__Depression
__Physical abuse
__Fearful
__Loneliness
__Nightmares
__Overweight
__Child abuse
__Nail biting
__Underweight
__Can't decide
__Palpitations
__Feel panicky
__Unemployment
__Over-ambitious
__Seeing things
__Eating disorder
__Angry
__Claustrophobia
__Bowel problems
__Can't have fun
__Hearing noises
__Money problems
__Suicidal ideas
__Take sedatives
__Fainting spells
__Unable to relax
__Memory problems
__School problems
__Sexual assault
__Sleeping trouble
__Depressed
__Marital problems
__Lack of appetite
__Can't keep a job
__Stomach problems
__Can't concentrate
__Lack of exercise
__Can't make friends
__Don't like weekends
__Bad home conditions
__Inferiority feelings
__Sexual problems
__Sexual abuse
__ADD (ADHD)

Other problems:

_____

_____

_____

Physical History- Check any that may apply, past or present:

__Heart problems
__Cancer
__Pain or pressure in chest
__High blood pressure
__Sexually transmitted
__Drug Abuse
__Allergies
__Bedwetting/soiling
__Pregnancy #___
__Liver problems
__Immune disease
__Severe headaches
__Head injury
__Stroke
__Epilepsy/convulsions
__Seizures
__PMS
__Abortion #___
__Shortness of breath
__Hepatitis/jaundice
__Diabetes
__Tuberculosis
__Alcoholism disease
__Asthma
__Kidney problems
__Hormone therapy

Family of Origin History (parents, siblings, grandparents, aunts, uncles)
Please circle any that apply:

Depression
Violence
Anxiety
Schizophrenia
Bipolar (manic/depression)
Child abuse/sexual abuse
Attention deficit disorder
School failure
Alcoholism
Jail
Trauma
Suicide
Gambling
Drug abuse
Eating disorder
Pornography

Alcohol or other substance use:
Please indicate past and current use.

Alcohol _____ age at 1st use _____ Last used _____ Amount _____ Frequency _____

Marijuana _____ age at 1st use _____ Last used _____ Amount _____ Frequency _____

Cocaine _____ age at 1st use _____ Last used _____ Amount _____ Frequency _____

Methamphetamine _____ age at 1st use _____ Last used _____ Amount _____

Frequency _____

Opiates _____ age at 1st use _____ Last used _____ Amount _____ Frequency _____

Others_____
_____
_____
_____
_____