

Client Intake Form

Last Name		Current Date	
First Name/MI		Birth Date	
Street Address		Phone/Home	
City/State/Zip		Phone/Other	
Education Level		Occupation	
Employer		Length of Present Employment	

Medical Information

Primary Care Clinic		Location/Address	
Primary Care Physician		Date when Dr. last seen	
Other Doctors/Therapists	1.	2.	3.
Medical History & Problems	Allergies to Medications:		Health is rated as: Excellent Good Fair Poor
<input type="checkbox"/> I do not have a primary care doctor			
Hospitalizations / Dates ----	Reason for hospitalization	Medications/Dosage/ Frequency:	
Hospitalizations for Mental health: <input type="checkbox"/> yes <input type="checkbox"/> no			

Family of Origin Information

Present during childhood: Mother Father Stepmother Stepfather Brother(s) Sister(s) Other (specify) _____ Notes: _____	Present part of childhood: Mother Father Stepmother Stepfather Brother(s) Sister(s) Other (specify) _____	Not Present at all: Mother Father Stepmother Stepfather Brother(s) Sister(s) Other (specify) _____	Parent's current marital status: Married to each other Separated for ___ years Divorced for ___ years Mother remarried ___x's Father remarried ___x's Mother involved w/someone Father involved w/someone Mother deceased ___ years Client age at her death ___ Father deceased ___ years Client age at his death ___
Age of emancipation from childhood home & Circumstances:		Describe Childhood Family Experience: Outstanding/Supportive Normal Chaotic Witnessed abuse _____ Experienced abuse _____	
Special Circumstances in childhood:			
Please note any familial mental health history:		Note family history of medical disease:	
Please note any familial alcohol or drug problems:			

Do you have any significant losses that have impacted your life? Discuss...

Relationship History

<p>Relationship Status :</p> <p>single, never married engaged _____months married for _____years divorced for _____years separated for _____years divorce in process for _____ months and/or _____years live-in for _____years _____prior marriages -self _____prior marriages - of partner</p>	<p>Re: Intimate Relationship</p> <p>never dated never in relationship not currently in relationship currently in relationship</p> <p>Relationship satisfaction:</p> <p>very satisfied satisfied somewhat satisfied dissatisfied very dissatisfied</p>	<p>Persons currently in home: Name: _____ age/gender _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List those NOT in Home:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Discuss frequency of contact/visits:</p>	<p>Relationship to client:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Discuss any past or current significant issues in **intimate** relationships:

Discuss any past or significant issues in other **immediate family** relationships:

Social History

Describe your **support network, extended family connections and friendships** and indicate if they are helpful:

Describe your **leisure activities/hobbies**

Briefly list **past jobs/occupations** and **length of employment:**

Discuss any **occupational problems** and indicate nature of the problem (performance, relational. safety):

Briefly list any **legal or court problems** and indicate whether past or present:

List any other **formal support (social workers, probation officers, faith community connections, etc.)**

Substance Use History

Substance used	First use age	Last age use	Current Y/N	Frequency	Amount
Alcohol					
Amphetamines/speed					
Barbiturates/downers					
Caffeine					
Cocaine					
Crack cocaine					
Hallucinogens (LSD)					
Inhalants (glue, gas)					
Marijuana/hashish					
Nicotine/cigarettes					
PCP					
Over the counter diet					
Over the counter/ other/prescription Rx's					

CAGE Assessment: Please indicate which statements apply to you:

- Have you ever felt the need to **CUT DOWN** on your drinking and/or drug use?
- Have you ever been **ANNOYED** by criticism of your drinking and/or drug use?
- Have you ever felt **GUILTY** about your drinking and/or drug use?
- Have you ever felt the need for an **EYE-OPENER** when you first get to work, or need for alcohol/drugs to keep functioning or to cope with withdrawal symptoms for going to work or a social event?

hangovers seizures blackouts overdose	withdrawal symptoms medical conditions tolerance changes (irritation) loss of control	sleep disturbance assaults suicidal impulse relationship conflicts	binges job loss arrests other _____
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Substance Use Status:

- No history of use---never used any substances
- No history of abuse/dependence
- Present and active use
- Have not used for at least 6 months
- Have not used for at least one year
- Have not used for more than 2 years
- Last time used:_____

Treatment History:

- outpatient – list date(s) _____
- in patient – list dates(s) _____
- 12 –Step Program (dates)_____
- Stopped on own (date)
- Other _____

Please describe why you have come to seek therapy. How does this impact your daily life?

What do you expect or want to get out of this therapy experience? How will you know therapy has been successful for you?

(Please turn over to continue....)

Please check all boxes that apply to your experience. Indicate how long you have had this problem.

<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Difficulty enjoying life	<input type="checkbox"/> Sad/tearful Mood	<input type="checkbox"/> Irritable Mood	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Self Injurious Behavior
<input type="checkbox"/> Difficulty Staying Asleep	<input type="checkbox"/> Low Energy-Fatigue	<input type="checkbox"/> Anxious Mood	<input type="checkbox"/> Agitation /Restlessness	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Isolation Withdrawn
<input type="checkbox"/> Early Awakening	<input type="checkbox"/> Feelings of discouragement	<input type="checkbox"/> Feelings of Shame/Guilt	<input type="checkbox"/> Touch-easily annoyed	<input type="checkbox"/> Often loses belongings	<input type="checkbox"/> Difficulty paying attention-difficulty concentrating
<input type="checkbox"/> Appetite Up/Down	<input type="checkbox"/> Feelings of Hopelessness	<input type="checkbox"/> Negative self talk	<input type="checkbox"/> Angry and/or resentful	<input type="checkbox"/> Disorganized	<input type="checkbox"/> Difficulty managing daily affairs
<input type="checkbox"/> Weight Up/Down	<input type="checkbox"/> Feelings of Helplessness	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Sexual problems	<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Poor Memory-forgetful
<input type="checkbox"/> Not eating/purging	<input type="checkbox"/> Feelings of Powerlessness	<input type="checkbox"/> Feelings of Worthlessness	<input type="checkbox"/> Relational difficulties	<input type="checkbox"/> Work Problems	<input type="checkbox"/> Difficulty making decisions
<input type="checkbox"/> Recent Postpartum	<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Chronic health issues	<input type="checkbox"/> Physical Symptoms (List)	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Experienced life threatening trauma/abuse	<input type="checkbox"/> Recurrent flashback of trauma-abuse event	<input type="checkbox"/> Recurrent recollections-re-living the event	<input type="checkbox"/> Nightmares of the trauma event	<input type="checkbox"/> Distress when reminded of the event	<input type="checkbox"/> Exaggerated startle response
<input type="checkbox"/> Numbness	<input type="checkbox"/> Difficulty trusting others	<input type="checkbox"/> Feeling detached from others	<input type="checkbox"/> Avoidance of anything related to the event	<input type="checkbox"/> Physical reactivity when reminded of event	<input type="checkbox"/> Difficulty remembering the event
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Fears/worries/negative thoughts	<input type="checkbox"/> Social anxiety	<input type="checkbox"/> Difficulty making friends	<input type="checkbox"/> Anxiety when separated from key people	<input type="checkbox"/> OTHER
<input type="checkbox"/> Fear of dying	<input type="checkbox"/> Agoraphobia-difficulty leaving home	<input type="checkbox"/> Performance anxiety	<input type="checkbox"/> Anxiety interferes with work	<input type="checkbox"/> Uses alcohol to calm anxiety	<input type="checkbox"/> OTHER
<input type="checkbox"/> Phobias	<input type="checkbox"/> Obsessive Thoughts/ images	<input type="checkbox"/> Compulsive-repetitive behaviors	<input type="checkbox"/> Anxiety interferes with relationships	<input type="checkbox"/> Uses food to calm anxiety	<input type="checkbox"/> OTHER
<input type="checkbox"/> Visual Hallucinations	<input type="checkbox"/> Delusional Thoughts	<input type="checkbox"/> Losing time	<input type="checkbox"/> Excessive Disorganization	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Problematic behaviors (list)
<input type="checkbox"/> Auditory Hallucinations	<input type="checkbox"/> Hallucinations-bodily sensations	<input type="checkbox"/> Paranoia	<input type="checkbox"/> Periods of wakefulness	<input type="checkbox"/> Excessive spending habits	<input type="checkbox"/> Gambling

Thank you for taking time to fill out this form as it helps us serve you better. Revised 020910