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INTAKE FORM

Today's Date: _____
(mm/dd/yyy)

Client Name: _____ **Date of Birth:** _____
(mm/dd/yyy)

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Form Completed By:
☐ **Client**
☐ **Representative**

Representative Name: _____
(If other than client)

Representative Relationship to Client: _____
(If other than client)

Primary Phone Number: _____ ☐ **Home** ☐ **Work** ☐ **Mobile** ☐ **Other:** _____

Secondary Phone Number: _____ ☐ **Home** ☐ **Work** ☐ **Mobile** ☐ **Other:** _____

Email: _____

If any, which number(s) may we leave a message on? ☐ **Home** ☐ **Work** ☐ **Mobile** ☐ **Other:** _____

Ethnicity: ☐ **White / Non-Hispanic** ☐ **Black / Non-Hispanic** ☐ **Hispanic** ☐ **Asian / Pacific Islander**
☐ **Native American Indian** ☐ **Other:** _____

Primary language spoken in the home: _____

Religion: ☐ **Christian (Protestant or Catholic)** ☐ **Jewish** ☐ **Muslim** ☐ **Other:** _____

CONCERNS AND PRESENTING ISSUES

Please describe your reasons for seeking counseling services at this time:

(Required)

When did these problems begin?

(Required)

Please provide any examples of the problem(s):

(Required)

If you need more space for any of the above fields, you may continue on the back of this page

Family Information

Current Marital Status:

☐ **Married (Date: _____)** *(mm/dd/yyyy)* ☐ **Divorced (Date: _____)** *(mm/dd/yyyy)*

☐ **Separated (Date: _____)** *(mm/dd/yyyy)* ☐ **Widowed (Date: _____)** *(mm/dd/yyyy)*

☐ **Never Married** ☐ **Partners (Living Together), not Married**

If applicable, please provide the following information for your current significant other:

_____ _____ _____

Name *Age* *Gender*

Do you have any children? ☐ **Yes** ☐ **No** **If Yes, how many?** _____

Please provide the following information regarding each child:

Name, Age, Gender, Relationship to Client

Medical History

Please provide the following information for any current or recent healthcare providers (i.e. physician, neurologist, psychologist, psychiatrist, etc.):

Name, Type of Provider, Phone Number

Please check any of the following that apply and list the age at which the problems began, as well as any other relevant information

Vision Problems ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Headaches ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Seizures ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Head Injuries ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Heart Problems ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Weight Gain ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Eating Difficulties ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Sleeping Difficulties ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Accidents ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Coordination Issues ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Hospitalizations ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Operations ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Alcohol or Drug Use ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Other Health Problems ☐ **No** ☐ **Yes** **If Yes, Age / Describe:** _____

Are you currently taking any medications? ☐ **No** ☐ **Yes**

If Yes, Please provide the following information for each medication

Medication name, Dosage, Frequency (How much & How often)

Please provide the following information for any significant and relevant family medical history (i.e. seizures, stroke, tumors, cancer, diabetes, etc.)

Family member relation (i.e. Maternal / Paternal father, grandmother, sister, brother, uncle, aunt), Relevant health issue or concern

Mental Health History

Have you ever had any psychological or neurophysiological evaluation? ☐ **No** ☐ **Yes**
If yes, please provide the following

Date, Psychologist name

Have you ever had a psychiatric evaluation? ☐ **No** ☐ **Yes**
If yes, please provide the following

Date, Provider name

Have you ever been hospitalized for mental health concerns? ☐ **No** ☐ **Yes**
If yes, list dates and describe

Please describe any symptoms or other issues you may have or may have experienced to a degree which has interfered with your daily functioning (i.e. anxiety, depression, behavioral problems, etc.):

Please list any family history of mental health issues (i.e., depression, substance abuse, etc.) and the family member (i.e., maternal grandmother, paternal uncle, etc.):

Mental Health Issue / Concern, Family Member

Educational / Social History

Highest level of education completed?

☐ Elementary / Middle School ☐ Some High School ☐ High School ☐ GED / High School Equivalent

☐ Undergraduate (College) ☐ Graduate School (College)

Are you currently employed? ☐ No ☐ Yes

What is your profession? _____

How would you describe your friendships?

☐ Good ☐ Average ☐ Poor

Do you have close friends?

☐ Yes ☐ No

Please share any additional information regarding your relationships:

Please check any of the following events if you you have experienced them within the past two years:

☐ Moving to a new home ☐ Job or career change ☐ Married / Committed ☐ Separation

☐ Divorce ☐ Death of a spouse ☐ Death of a family member ☐ Job loss ☐ Had a child

☐ Returned to school ☐ Graduated from school ☐ Major illness or personal injury

☐ Other: _____

Please describe your likes, dislikes, hobbies, interests, sports, leisure activities, etc.

Please briefly describe any further information you believe would be helpful

****** Additional page for any sections which could not be completed above ******

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