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Intake Information Form
(To be completed by client)

Today's Date:

Adult #1 Name: SS#:

Adult #2 (spouse/partner): SS#:

Address: City: ZIP:

Home Phone: Insurance Co: Member ID#:

Referred by: Insured: Insured DOB:

If billing to insurance please present card to be copied

ADULT # 1: Date of Birth: Age: Sex:

Occupation: Place of Business:

Work Address:

Work Phone: Cell Phone: Email:

ADULT #2: Date of Birth: Age: Sex:

Occupation: Place of Business:

Work Address:

Work Phone: Cell Phone: Email:

Check your current living situation: Married/Committed Divorced Separated Single

Cohabitating Engaged Remarried/Blended Significant Other Widowed

How long have you been in this living situation?

Have either you or your spouse/partner been married before?

How long were each of you married to ex-spouse?

Children/Siblings

Name: Sex: DOB: Type (child or sibling, bio, step, etc.): Living with You?

BASIC HEALTH AND COUNSELING HISTORY

ADULT # 1: Good Fair Poor When was your last physical exam?

Who is your Physician?

Are you taking any prescribed or over the counter medications, or supplements at this time?

Yes No. If yes, what?

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes No, If yes, what?

How often have you used: Alcohol Marijuana Any Other Mood Altering Substances in the Last Month? None, 1-5 times, 5-10 times, more than ten times.

Have you been in counseling before? From: _________ To: __________ With Whom?

For What?

Have you ever been hospitalized? Yes No, If so, for what?

ADULT #2: Good Fair Poor When was your last physical exam?

Who is your Physician?

Are you taking any prescribed or over the counter medications, or supplements at this time?

Yes No, If yes, what?

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes No, If yes, what?

How often have you used: Alcohol Marijuana Any Other Mood Altering Substances in the Last Month? None, 1-5 times, 5-10 times, more than ten times.

Have you been in counseling before? From: ______ To: _____ With Whom?

For What?

Have you ever been hospitalized? Yes No If so, for what?

CHILDREN'S HEALTH HISTORY:

If your children have any physical, emotional, or mental condition now or in the past indicate:

Child name: Has this child ever been hospitalized? Yes No

If so, for what?

Is this child taking any prescribed or over the counter medications, or supplements at this time?

Yes No. If yes, what?

Have they been in counseling before? From: _____ To: _____ With Whom?

For What?

Child name: Has this child ever been hospitalized? Yes No

If so, for what?

Is this child taking any prescribed or over the counter medications, or supplements at this time?

Yes No. If yes, what?

Have they been in counseling before? From: _____ To: _____ With Whom?

For What?

More than two children, indicate if more health information is needed here: Yes No

FAMILY SOCIAL FUNCTIONING:

Leisure Activities: Hobbies:

Activities with others: Clubs/Organizations:

Special Skills:

Recent Changes:

FAMILY SPIRITUALITY/FAITH/MEANING IN LIFE:

Describe your spiritual beliefs:

Source of Security/Significance:

Current Stressors:

Methods of Coping:

REASON(S) FOR SEEKING COUNSELING TODAY:

Briefly describe the problem for which you wish to have counseling?

What do you hope to be able to do when you have completed counseling?

Please circle any of the following that presently cause you difficulty:
(Use initials if more than one member is seeking care.)

Assertiveness	Health problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation .
Bedwetting	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Physical abuse	Children	Parents	Insomnia
Education	Divorce	Relaxation	Ambition
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug Use	Self Harm	Tiredness
Headaches	Finances	Appetite	School
Unhappiness	Fears	Work	Confusion
Premarital	Food	Self-control	Sadness
In-laws	My past	Guilt	Other ______________

Please put an * by the items that are causing you the MOST difficulty.