# Client Intake Form

**CLIENT INFORMATION**

First Name: _____ MI: _____
Last Name: _____
Address : _____
_____
City: _____ State: _____ Zip: _____

Date: _____
Home PH: _____
Work PH: _____
DOB: _____ /_____ /_____
____ Male ____ Female
SSN: _____ - _____ - _____

Physician(s): _____

Current Medications

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

Past Medications

| Medication | Dosage | Frequency | Last Date Taken |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Briefly describe the reason for seeking counseling at this time:_____

_____

_____

_____

How were you referred to this center? _____

_____

Have you ever sought counseling before? ____ Yes ____ No

If yes, WHEN and WHERE: _____

_____

Check any of the following causing you difficulty :

| | | |
|---|---|---|
| ____ Assertiveness | ____ Nightmares | ____ Children |
| ____ Health | ____ Loneliness | ____ Parents |
| ____ Career Choices | ____ Concentration | ____ Insomnia |
| ____ Sexual Issues | ____ Separation | ____ Stress |
| ____ Being a Parent | ____ Self-concept | ____ Divorce |
| ____ Alcohol Use | ____ Self-control | ____ Relaxation |
| ____ Legal Matters | ____ My thoughts | ____ Ambition |
| ____ Past Issues | ____ Nervousness | ____ Anger |
| ____ Depression | ____ Marriage | ____ Dating |
| ____ Suicidal Thoughts | ____ Religion | ____ Friends |
| ____ Finances | ____ Fears | ____ School |

Please describe any other areas of difficulty: _____

_____

**PERSONAL INFORMATION**

Please answer the following questions so that your therapist will have some understanding of your situation. Only your therapist will read this information, and it will remain strictly confidential along with any other personal information you provide. Feel free to leave any of these questions unanswered.

Occupation: _____ How long: _____

Place of Employment: _____

Hobbies: _____

Goals: _____

EDUCATION: (Circle highest grade completed)

| | Elementary | Jr. High | High School | College |
|---|---|---|---|---|
| Grade: | 1 2 3 4 5 | 6 7 8 | 9 10 11 12 | 1 2 3 4 |

Other Education or Training: _____

MARITAL INFORMATION: ____ Single ____ Married ____ Widowed ____ Divorced
Previously married: ____ Yes ____ No (if "yes" # of times ____ )

Spouse name: _____ DOB: ____ / ____ / ____

Spouse's occupation and employer: _____

**List all persons living in the home:**

| Name | Age | Sex | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List other children not in the home:**

| Name | Age | Sex | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please write any other necessary information below that may not have been addressed in this intake form that will help clarify circumstances bringing you to therapy (e.g. if services are court mandated).