

Client Intake Form

How were you referred to me?

What brings you to counseling at this time?

What are your goals for counseling?

Have you seen a mental health professional before?

Yes

No

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol?

Yes

No

Do you use recreational drugs?

Yes

No

Do you have suicidal thoughts?

Yes

No

Have you ever attempted suicide?

Yes

No

Do you have thoughts or urges to harm others?

Yes

No

Have you ever been hospitalized for a psychiatric issue?

Yes

No

Is there a history of mental illness in your family?

Yes

No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others? With family, etc...

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- Increased appetite
- Decreased appetite
- Trouble concentrating
- Difficulty sleeping
- Excessive sleep
- Low motivation
- Isolation from others
- Fatigue/low energy
- Low self-esteem
- Depressed mood
- Tearful or crying spells
- Anxiety
- Fear
- Hopelessness
- Panic

Please check any of the following that apply

- Headache
- High blood pressure
- Gastritis or esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic pain
- Loss of consciousness
- Heart attack
- Bone or joint problems
- Seizures
- Kidney-related issues
- Chronic fatigue
- Dizziness
- Faintness
- Heart valve problems
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer

What else would you like me to know?