



ADULT CLIENT INTAKE INFORMATION SHEET

Name: First _____ Mi _____ Last _____ **Age:** _____ **DOB** _____

Address: _____ **Apt. #:** _____

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

Ethnicity: (Circle one) White Black Native American Asian Hispanic Other

Gender: Male Female **Social Security Number:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Preferred Method for Courtesy Appointment Reminders:

Do not remind me Call to Home Phone Call to Mobile Phone Call to Work Phone

You are responsible for appointments you schedule whether you receive a courtesy call or not.

Emergency Contact: _____ **Phone:** _____

Marital Status: Single Married Widowed Separated Divorced Domestic Partner

Employment: Employed Unemployed Student Disabled

Occupation: _____ **Employer:** _____

Were you referred to our office? _____ **If yes, by whom?** _____

Internet Phone Book Friend or relative Clergy Doctor _____

Responsible Party: (list the name of the person who is financially responsible for your account)

Individual's Name: _____ **Phone:** _____

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

Primary Insurance Coverage:

Policy holder's Last Name _____ First _____

Birth date: _____ Sex: **M** **F** Relation to client _____

Social Security # _____ Employer _____

Insurance Company _____

Policy ID # _____ Group ID# _____

Current Problem: (Describe the problem/s for which you are now seeking help.)

Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signed: _____ **Date:** _____ **PHI File**

Clinical Intake Information

Client Name: _____

How long have you been experiencing this problem? _____

What have you done to try to solve this problem? _____

How successful have your efforts been in solving the problem? Unsuccessful Successful

Have you had any prior counseling? Yes No If yes, please complete the following:

Counselor	Dates	Nature of Problem
_____	_____	_____
_____	_____	_____

Other Current Problems (please rate: 0=none, 1=mild, 2=moderate, 3=severe)

- | | | | |
|----------------------|---------------------|-------------------------|-------------------|
| _____ marriage | _____ divorce | _____ alcohol/drug | _____ faith |
| _____ premarital | _____ child custody | _____ addictions | _____ religion |
| _____ singleness | _____ disabled | _____ grief/loss | _____ past hurts |
| _____ sexual issues | _____ work/career | _____ codependency | _____ depression |
| _____ family | _____ school | _____ fear/anxiety | _____ intimacy |
| _____ children | _____ money | _____ anger control | _____ mood swings |
| _____ parents | _____ aging | _____ communications | _____ loneliness |
| _____ in-laws | _____ weight | _____ stress management | _____ distrust |
| _____ hearing voices | _____ aches/pains | _____ seeing things | _____ self esteem |

Critical Stress Information

Have you had thoughts about harming yourself? Yes No

If yes, how recently? How often? _____

Have you had thoughts about harming others? Yes No

If yes, when? _____

Have you experienced any of the following:

Hospitalization or incarceration for suicidal or assaultive behavior

Where Hospitalized? _____ Dates _____

Length of Stay? _____ Reason _____

Homicidal or assaultive thoughts or feelings or anger control problems?

Threats of significant loss or harm (illness, divorce, custody, job loss?)

Clinical Intake Information

Client Name: _____

Personal History

List name, age, sex and relationship of all children:

Name	Age	Sex	Biological or Step	Living at Home	
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No
_____	_____	_____	_____	Yes	No

Marital Status (more than one answer may apply)

Single
 Separated
 Divorce in Process
 Unmarried
 Living together
 Widowed
 Annulment
 Married # of times _____ Length of Time _____, _____, _____, _____

Medical Information

Family Doctor: Name: _____ Address: _____ Phone: _____

Date of last physical: _____

Describe any medical problems or surgeries:

Are you presently taking any medication? Yes No

Prescription Medication	Dosage/Frequency	Reason	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over the Counter Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____

Are you experiencing difficulties or changes in any of the following?

Eating
 Sleeping
 Weight
 Pain
 Sex Drive

Sexual History (The following questions involve sensitive issues. Please answer if you feel comfortable.)

Sex was an uncomfortable or negative topic in the home in which I grew up. Yes No
 I have been, or suspect I have been sexually abused. Yes No
 Sex is unpleasant for me. Yes No

Please offer any explanation that would be helpful:

Clinical Intake Information

Client Name: _____

Spiritual/Religious

How important are spiritual or religious matters to you? Not Little Some Much
Are you affiliated with a spiritual or church group? Yes No
Would you like your spiritual/religious belief incorporated into your counseling? Yes No
Are you participating in any other spiritual or recovery groups? If so, please list groups attended:

Legal

Are you involved in any active case, civil or criminal? Yes No
Are you presently on probation or parole? Yes No
Past History: DWI, DUI: Yes No
Criminal Involvement _____

Education

High School/GED Graduate Last Grade Completed _____
Vocational Technical: Number of years _____
College: Number of years _____ Graduated Yes No Degree: _____
Other Training: _____
Currently Enrolled: _____
Career of Choice: _____

Social Information

Would you say that you have several relationships you enjoy with people outside your family? Yes No

What do you do for recreation and hobbies? How much time do you spend each week?

List community or other organizations (PTA, kid's sports, church groups, etc.) with which you are involved. How much time do you spend in these activities each week?

Please describe your level of physical activity, how long you have participated and the frequency of your participation?

Clinical Intake Information

Client Name: _____

Extended Family History

Name	Relationship	Living	Describe Relationship		
_____	_____	_____	Good	Ok	Bad
_____	_____	_____	Good	Ok	Bad
_____	_____	_____	Good	Ok	Bad
_____	_____	_____	Good	Ok	Bad

What was the atmosphere in your home while you were growing up?

If you were adopted, please describe your current relationship with your birth parents.

Has anyone in your immediate family committed suicide? Yes No

If yes, who? _____



Having read and completed the Personal History form, I hereby declare that the information I have given is correct and complete, to the best of my ability.

Signed: _____ Date: _____

(Thank you for taking the time to fill out the Personal History Information Sheet. Your counselor will use it to best assist you in our counseling work. We will maintain your strict confidence regarding this information, subject to the exceptions noted in the Client Information and Consent for Counseling Form.)