Client Intake Form

Adult Personal History

Your Name: ______________________________ Age: ___________ Date: ______________________

Occupation: ______________________________ Marital Status: ___________________________________

Check all that apply to you:

- ☐ Abuse
- ☐ Anger
- ☐ Anxiety/Fears
- ☐ Avoidance
- ☐ Chronic Pain
- ☐ Depression
- ☐ Drug/Alcohol Use
- ☐ Eating Concerns
- ☐ Faith Concerns
- ☐ Friendship Concerns
- ☐ Grief/Loss
- ☐ Headaches
- ☐ Health Concerns
- ☐ Irritability
- ☐ Life Changes
- ☐ Loneliness
- ☐ Nervousness
- ☐ Panic Attacks
- ☐ Parenting Problems
- ☐ Pornography
- ☐ Problems at work
- ☐ Recent Weight Loss/Gain
- ☐ Relationship Problems
- ☐ Self Worth
- ☐ Separation
- ☐ Sexual Problems
- ☐ Sleep problems
- ☐ Stress
- ☐ Suicidal Thoughts
- ☐ Trouble Concentrating
- ☐ Worrying
- ☐ Other: ______________ ____________________

List significant members for your family/or all others:

Name	Relationship	Age	Living with you?

Would you like to see any of these relationships improve? If yes, which ones?

____

Have you received psychiatric or psychological treatment or counseling before? YES NO

If yes, what worked and what did not? ____

____

Are there any special, unusual, or traumatic circumstances that affected your development?

____

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Is there a history of child abuse? YES NO

Is there any family history of mental health concerns? Explain.

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____

How important to you are spiritual matters? ____

Would you like your spiritual beliefs incorporated into the counseling? ______________________

What is the highest level of education you have completed? ____________________________

Other types of training? ____

Any significant medical concerns or problems? ____

____

Current Medications:

Medication	Dose	Frequency	Purpose

Chemical Use History:

- ☐ Alcohol
- ☐ Barbiturates
- ☐ Valium
- ☐ Cocaine
- ☐ Heroin
- ☐ Marijuana
- ☐ PCP/LSD
- ☐ Inhalants
- ☐ Caffeine
- ☐ Nicotine
- ☐ Prescription Drugs
- ☐ Other:_____________

Has the use of any of these substances affected your quality of life in a negative way? _______________

What do you like to do for leisure? What are some of your hobbies? How often? ___________________

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____

Who are your closest friends? ____

Do you have difficulty making or keeping friends? YES NO

Is there anything else you would like to discuss more in our sessions?

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What are your goals for therapy?

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____

What are some of your strengths?

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What part of you do you want to improve?

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