# Counseling Intake Form

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**Client's name**: ______________________________________**Date**: __________

Primary reason(s) for seeking services today:

____________________________________________________________________

____________________________________________________________________

Please check behaviors and symptoms that occur more often than you would like them to:

__ Aggression
__ Alcohol dependence
__ Anger
__ Anxiety
__ Chronic Pain
__ Compulsive behavior
__ Concentration Problems
__ Cyber addiction
__ Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug dependence
__ Eating disorder

___ Fatigue
___ Flashbacks
___ Grief
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Hyperactivity
___ Impulsivity
___ Irritability
___ Loneliness
___ Memory impairment
___ Mood swings
___ Obsessive Thoughts

___ Panic Attacks
___ Phobias/Fears
___ Poor judgment
___ Self-Esteem Problems
___ Sexual Difficulties
___ Sleep problems
___ Social Withdrawal
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Unresolved Trauma
___ Worrying
___ Other (specify): _______
________________________

## Employment

Please check employment status:

__ *employed full-time* __ *employed part-time* __ *unemployed* __ *disabled* __ *retired*

If currently employed, please list job information below:

Employer ________________________ Job Title __________________ How long there? ______________

### Family/Living Situation

__ Single __ Partnered __ Married __ Separated __ Divorced __ Widowed

Name of Spouse or Partner:____________________ age: ___ How long together?_____

Children: ______________________ age: ____ Living with you? Yes No

______________________ age: ____ Living with you? Yes No

______________________ age: ____ Living with you? Yes No

## Counseling/Prior Treatment History

Have you had any prior professional counseling or psychiatric treatment? __ Yes __ No

If yes, please list most recent treatment episodes, who treated you, and outcome below:

| *Approximate Treatment Dates* | *Treatment Provider/Facility* | *Outcome* |
|---|---|---|
| ________________________ | ________________________ | ____________ |
| ________________________ | ________________________ | ____________ |

## Medication and Chemical Use History

*Have you ever been treated for alcohol or drug dependence/abuse? ___ Yes ___ No*

*Have you ever felt like you should cut down on alcohol or other drug use? __ Yes __ No*

*Has a friend or relative ever discussed concerns about your drug use? __ Yes __ No*

*Have you ever felt guilty about your drinking or drug use? __ Yes __ No*

*Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __Yes __ No*

*Is there a history of problems with alcohol or drug use in your family? ___ Yes ___ No*

## Medical/Physical Health

List any current health concerns: ________________________________________________

Primary Care Physician's Name and Phone Number: ______________________________

| **Current Prescribed Medications** | **Dose** | **Frequency** | **Purpose** | **Side effects** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Family History/Development

List any pertinent family history of medical, mental health, or substance abuse problems: _______

________________________________________________________________________

Have you ever been a victim of sexual, physical, emotional, or verbal abuse? __ Yes __ No

Are there other unusual/traumatic circumstances that affected your development? __ Yes __No

If Yes, please describe: ______________________________________________

________________________________________________________________________

______________________________ ______________

Therapist's signature Date