Client Intake Assessment

Client Name____________________________ Date_________________
Home Phone______________ Cell Phone____________ Work Phone___________
Address___________________________________ City____________ Zip____________
Date of Birth_____________________
Age_______ Gender____________ Ethnicity/Heritage__________________________
Email Address_______________________________
Why are you seeking counseling?____
____
____

Marital/Family Information

#of Full Siblings___________ #of Half Siblings__________
Birth Order___________ Age/Gender of siblings____________
__single __married __separated __divorced __widowed __domestic partnership
Mother's Name______________________ Occupation_______________________
Age___________ Is there contact?____ Please Explain_____________________
History of Mental Illness? If yes, please explain.____________________________________
History of Alcohol/Drug Abuse? If yes, please explain.________________________________
____
Any additional comments____
____
Father's Name_____________________ Occupation________________________
Age__________ Is there contact_____ Please explain_________________________
History of Mental Illness? If yes, please explain______________________________________
History of Alcohol/Drug Abuse? If yes, please explain.__________________________________
____
Any additional comments____
____

Current Life Situation

Who do you live with____
Current Occupation_______________________________
__Homemaker __Never Employed __Part Time __Full Time __Sick Leave
__Poor work History __On Disability (please comment)________________________________
Current Financial Situation____
Does your spouse/partner work?_____If so, where and in what position____________________
What other jobs have you had in the last 15 years____
____
Any work related problems you have, or have had?_____________________________________
____

Have you lived anywhere else other than your current residence? If so, please explain_________
____
____
Divorce History? If yes, please explain____
Any current custody disputes? If yes, please explain____________________________________

Family History

Do you have any children or stepchildren? If so, please give names and ages________________
____
____
Please indicate, to the best of your knowledge, what life was like growing up

__Upper Class __Middle Class __Low Socioeconomic Class __other__________
__chaotic __abusive __Open communication __addiction __Closed off

Please explain your answers if you desire____
____
Is there anyone still alive in your family that you are no longer in contact with? Is so, whom and why?____
____
Who was in your family while you were growing up?__________________________________
____
Where are they now?____
____

Educational/Social History

___Easily forms friendships ___Attends social functions __Needs social interactions
___Maintains friendships ___avoids social functions __supportive friends
___no close friends

How many friends do you have?_________
What is your highest level of education?

__grade school __middle school __high school __community college __Bachelor
__ doctoral __some college __GED

Educational Concerns: __good grades __avg grades __grade concerns __special education
Please explain any learning disabilities and/or special education requirements as you understand them.____
____

School Behaviors (childhood)

__Truancy __Argues __Fighting __Poor efforts __Disruptive __Attentive __Respectful
__supportive __repeated grade __expulsions __suspensions __Difficulty with peers
Were there any support figures in your life? If so, who and what did they support you with_____
____
Any other comments____
____

Military History
__no military time __spouse in military __raised in military family
__Army __Navy __AirForce __Marines __Coast Guard __Other________________
Dates of service____
Combat dates, if applicable____
__Honorable __Dishonorable __Medical __AWOL __Service related disability
__Treatment at VA Hospital
Other comments____
____
____

Spiritual/Religious
What is your religious/spiritual background______________________________________
How important is religion/spirituality __not __Little __moderate __very
Are you currently affiliated with a spiritual or religious group? If so, please explain_______
____
Were you raised within a spiritual or religious group? If so, please explain_______________
____
Would you like your spiritual or religious beliefs incorporated into counseling? If so, please explain____

Legal
Do you have current/past legal problems, arrests, etc.__________________________________
Traffic violations __no __yes DUI/DWI, etc. __no __yes
Criminal Involvement __no _yes Civil Involvement __no __yes
If you responded yes to any of the above, please fill in the following information

Charges	Date	Where(city,st)	Results
________________	________	______________	_______________________
________________	________	______________	_______________________
________________	________	______________	_______________________
________________	________	______________	_______________________
________________	________	______________	_______________________

Are you presently on probation or parole __no __yes
If yes, please describe____
____

Leisure/Recreational
Describe special areas of interest or hobbies (art, books, crafts, fitness, sports, outdoor activities, church activities, walking, walks, diets, travel, photography, etc.)

Activity	How often	How often in the past

Medical/Physical Health

__AIDS __Constipation __Hepatitis __Sore Throat __Mononucleosis __Chicken Pox
__High Blood Pressure __Abdominal Pain __Dental Problems __Kidney Problems
__Sinusitis __Anemia __ Mumps __Dizziness __Diabetes __Measles __Diabetes
__Allergies __Diarrhea __Stroke __Sexual Problems __Asthma __Toothache __Cancer
__Menstrual Pain __Tonsillitis __Ear Infections __Bronchitis __Fainting __Nose Bleeds
__Eating Problems __Thyroid Problems __Bed Wetting __Vision Problems __Fatigue
__Pneumonia __Chest Pain __Colds/Coughs __Frequent Urination __Vomiting
__Hearing Problems __Sleeping Difficulty __Whooping Cough __STD's __Chronic Pain
__other (describe)____

Please check if there have been any recent changes in the following:
__sleep patterns __eating patterns __behavior __energy level
__physical activity level __general mood __weight __nervousness/tension
Describe the changes indicated____
____
List any current health concerns____
____
List any recent health or physical changes____
____

Meals	**How often**	**Typical Foods eaten**
Breakfast	**_________/week**	**_________________________________**
Lunch	**_________/week**	**_________________________________**
Dinner	**_________/week**	**_________________________________**
Snacks	**_________/week**	**_________________________________**

Current Prescribed Medication Dose Dates Purpose Side effect
____
____
____

Current over the Counter Dose Dates Purpose Side Effect
Vitamins, herbs, meds
____
____
____

Family History of Medical Problems____
____
____
____

Are you allergic to any medications or drugs. If yes, please explain_________________________
____

Are you sexually active? __no __yes
Are you on birth control? __no __yes (if yes, what method do you use)____________________

	Date	Reason	Result
Last Physical	___________	__________________	___________________
Last Doctor Visit	___________	__________________	___________________
Last dental Exam	___________	__________________	___________________
Most recent Surgery	___________	__________________	___________________
Other Surgery	___________	___________________	___________________
Upcoming surgery	___________	___________________	___________________

Chemical Use History

	Method of Use	Frequency	Age at First Use	Age at Last Use	Used in last 48 hrs. yes/no	Used in last 30 days Yes/no	How many times
Alcohol							
Barbiturates							
Valium/Librium							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over the counter							
Prescriptions							
Other							

Substance of preference
1.___________________ 2.__________________
3.___________________ 4.__________________
Please describe when and where you typically substances_________________________________
____
Have there been changes in your level of use or patterns? If so, please describe______________
____
Describe how your use has affected your family and/or friends (please include their perceptions of your se)____
____
Reasons for use
__addicted __Build confidence __escape __Self medication
__Socialization __taste __other(specify)____________________________________

How do you believe your substance use affects your life?______________________________
____
Who or what has helped you in stopping or limiting your use?___________________________
____
Have you had withdrawal symptoms when trying to stop use of drugs or alcohol? Explain_____
____
Have you had adverse reactions or overdose to drugs or alcohol? Explain.__________________
____
____
Does your body temperature change when you drink? Explain_____________________________
____
Have drugs or alcohol created a problem for you at the workplace? Explain_________________
____

Counseling/Prior Treatment History

	No	Yes	When	Where	Reactions to your experience
Counseling/Psychiatric Treatment					
Suicidal Thoughts/attempts					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self help groups					

Have any family members or significant others had counseling or treatment? Explain_________
____
____

Please check behaviors and symptoms that occur to you more often than you would like them to take place (current behaviors and/or symptoms)

__Aggression __Alcohol Dependence __Anger __Antisocial Behavior __Anxiety
__Avoiding People __Chest Pain __Cyber Addiction __Depression __disorientation __Distractibility
__Dizziness __Drug Dependence __Eating Disorder __elevated Mood __Fatigue __Gambling __Hallucinations
__Heart Palpitations __High blood pressure __Hopelessness __Impulsivity __Irritability __Judgment Errors
__Memory Impairment __Moods Shifts __Panic Attacks __Phobias/Fears __Recurring thoughts
__sexual addictions __Sexual difficulties __Sick often __Sleep problems __Speech problems
__suicidal thoughts __Thought disorganization __Trembling __Withdrawing __Worrying
__other (describe)____

Any current suicidal thoughts/plans? If yes, what are your thoughts/plans____________________
____

Are you currently experiencing any health issues? Explain_________________________________
____

Briefly discuss how the above symptoms impair your ability to function effectively___________
____

Please include any additional information that would assist in understanding your problems and/or concerns.____
____
____
____