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Client Intake Form - Adult

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Identified Gender _____ Preferred Pronouns _____

Address _____

Contact Phone Number(s) Cell _____

Other _____

Contact E-Mail Address _____

Status: ☐ Single ☐ Married ☐ Partnered ☐ Div. ☐ Widowed ☐ Other

Number of children _____ Ages of children _____

Occupation _____ Employer _____

Ethnicity _____ Religion _____

EMERGENCY CONTACT NAME _____

* Please note, as stated in the “Safety” section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Are you currently working with a physician, psychiatrist, or other healthcare provider? ☐

Name & Practice Name _____

Would you like me to coordinate with this provider? ☐ YES ☐ NO

Client Health History

History of Mental Health Services: _____

History of Psychiatric medication ☐ YES ☐ NO

List: _____

Current Medications ☐ YES ☐ NO

List: _____

Previous Mental Health diagnosis ☐ YES ☐ NO

List: _____

Relevant Medical Diagnosis: _____

History of substance use/abuse? ☐ YES ☐ NO Current? ☐ YES ☐ NO

Generally, how do you sleep? Check all that apply:

☐ *Great!* ☐*OK* ☐*Hard to fall asleep* ☐*Hard to wake up* ☐*Wake up frequently at night*

Generally, how often are you active (exercise, play, garden, etc.)? Check all that apply:

☐ *Hardly ever* ☐*1x per week* ☐*2-3 times per week* ☐*4x or more per week* ☐*Daily*

Please list your current hobbies _____

Are others concerned about the amount of alcohol you drink / your recreational drug use? ☐ Yes ☐ No

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No
If yes, when? _____

Have you ever made a plan to commit suicide or attempted suicide? ☐ Yes ☐ No
If yes, when? _____

Do you currently have thoughts of ending your life, or acting recklessly in a way that would kill you? ☐ YES ☐ NO

Please list additional information you would like me to know

_____

_____

Client Interest in Counseling Services

Briefly Describe…

What brought you to counseling today?

What goals do you have for counseling?

Please check any of the following that currently apply to you:

☐ Anxiety	☐ Depression	☐ Money Issues
☐ Stress	☐ Sexuality	☐ Suicidal Thoughts
☐ Self-esteem	☐ Abuse	☐ Worry/Fear
☐ Sleep Changes	☐ Cutting/Self-Harm	☐ Trauma
☐ Anger	☐ Life Transitions	☐ Grief and Loss
☐ Disordered Eating	☐ Worry/Fear	☐ Health Concern
☐ Self-Control	☐ Drug/Alcohol Use	☐ Decision Making
☐ Strained relationship(s)		

Other: _____

What do you consider to be your strengths?

Thank You.