Confidential Client Intake Summary

Demographics

Last Name: _____ First Name: _____ Date:_____

Address: _____ City: _____ State_____ Zip: _____

Birthdate (DD/MM/YYYY): _____ Social Security Number: _____

I cannot guarantee confidentiality when you and I are communicating via cell phone, cordless phone, fax, email, mail or computer. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools.

Home Phone: _____-_____-_____ May we leave a message at this number? Yes __ No __

Cell Phone: _____-_____-_____ May we leave a message at this number? Yes __ No __

Email Address: _____ May we leave a message at this address? Yes __ No __

I prefer to receive appointment reminders via:

- ☐ **Phone Call/Voicemail**
- ☐ **Text Message (cell phone carrier: _____)**
- ☐ **Email**

Are you interested in E-statements to review your account online? Yes __ No __

Emergency Contact: _____ Relationship: _____
Phone: _____-_____-_____ Address: _____

Marital Status:

- ☐ **Single**
- ☐ **Married**
- ☐ **Divorced**
- ☐ **Partnered**
- ☐ **Widowed**
- ☐ **Spouse/Partner's Name: _____**

Employment Status:

- ☐ **Full-time**
- ☐ **Part-time**
- ☐ **Unemployed, Seeking**
- ☐ **Unemployed, Not Seeking**
- ☐ **Retired**
- ☐ **Active Military Duty**
- ☐ **Retired Military**
- ☐ **Other: _____**

Student Status:

- ☐ **Not a student**
- ☐ **Full-time**
- ☐ **Part-time**
- ☐ **School Name: _____**
- ☐ **Grade: _____**
- ☐ **Area of Study: _____**

How did you find us?

- ☐ **Colleague**
- ☐ **Employer**
- ☐ **Family Member**
- ☐ **Friend**
- ☐ **Online Search**
- ☐ **Physician**
- ☐ **Psychology Today**
- ☐ **Other: _____**

Presenting Symptoms/Concerns (please check any of the following that apply):

- ☐ Anxiety/Worry
- ☐ Panic Attacks
- ☐ Fear
- ☐ Irrational Fear
- ☐ Intrusive Thoughts
- ☐ Intrusive Rituals
- ☐ Sadness
- ☐ Crying Spells
- ☐ Hopelessness
- ☐ Restlessness
- ☐ Anger
- ☐ Frustration
- ☐ Confusion
- ☐ Shyness
- ☐ Loneliness
- ☐ Shame
- ☐ Guilt
- ☐ Disorganization
- ☐ Feeling Inadequate
- ☐ Stress
- ☐ Difficulty Coping
- ☐ Boredom
- ☐ General Unhappiness
- ☐ Loss of motivation
- ☐ Loss of interest
- ☐ Intrusive Memories
- ☐ Grief
- ☐ Mood Swings
- ☐ Impulsivity
- ☐ Loss of Independence
- ☐ Difficulty Sleeping
- ☐ Difficulty Waking
- ☐ Difficulty Communicating
- ☐ Difficulty making decisions
- ☐ Difficulty Concentrating
- ☐ Alcohol/Drug Abuse
- ☐ Restriction of food
- ☐ Binging/Purging
- ☐ Occupational Problems
- ☐ Relationship Issues
- ☐ Intimacy Issues
- ☐ Gender Issues
- ☐ Sexuality Issues
- ☐ Memory Loss
- ☐ Memory Impairment
- ☐ Chronic Pain
- ☐ Headaches
- ☐ Digestive Problems
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Legal Issues
- ☐ Financial Concerns

Psychosocial History

(If you need or desire more space to answer any of these questions, please use the back of this form)

Counseling Focus and Needs

Brief description of why you're seeking counseling:

_____
_____
_____

In what ways are the presenting issues or symptoms described above interfering with your daily functioning?

_____
_____
_____

What do you see as your strengths?

_____
_____
_____

What things have you done to try and address this issue, prior to seeking counseling?

_____
_____
_____

Briefly identify your goals for counseling and the areas of your life you wish to seek change in:

_____
_____
_____

Educational/Occupational Background

Highest Level of Education Completed: _____ Year Completed: _____

School most recently attended/Graduated from: _____Area of Study: _____

Please describe current employment, if any (employer, occupation, length of time in this role):

_____

Are you currently experiencing any impairment in educational or occupational functioning?

_____

Cultural/Social/Family History

Cultural Background (traditions, values, practices):

_____
_____

Ethnicity:

_____
_____

Religious/Spiritual Background:

_____
_____

Please briefly describe your family of origin and childhood circumstances (parents, siblings, birthplace, living arrangements, etc):

_____
_____
_____

Please briefly describe your current living circumstances:

_____

_____
_____

Please briefly describe your current relationship status (spouse/partner name, any relationship concerns):

_____
_____
_____

Do you have children? If yes, please list names, ages, genders, and any pertinent relationship details (past or current separations of family members, custody arrangements, etc.):

_____
_____
_____

Please briefly describe your current support system (persons, groups, community resources, etc):

_____
_____
_____

Medical and Psychiatric History

Briefly list and describe any current medical conditions or concerns (including allergies):

_____
_____
_____

Please list all Current Medications:

_____
_____
_____

Please list any previous medications that you are no longer taking:

_____
_____
_____

Please list any previous major illnesses, injuries, diagnoses, or surgeries:

_____
_____
_____

How do you rate your overall health? Excellent __ Good __ Fair __ Poor __

Do you exercise regularly? Yes __ No __ If yes, what types of exercise? _____

Primary Care Physician: _____ Practicing at: _____

Psychiatrist: _____ Practicing at: _____

Have you previously participated in outpatient counseling? Yes __ No __

If yes, please list all previous treatment providers, dates, and response to treatment:

_____
_____
_____

Previous mental health or medical hospitalizations? Yes __ No __
If yes, please briefly describe (treatment provider, dates, reasons for treatment, response to treatment):

_____
_____
_____

Please list any services you are currently utilizing with for management of your mental health/medical care (Physical Therapy, Speech Therapy, Pain Clinic, DHS, IHH, WIC, etc):

_____
_____
_____

Maternal Health History:

Are you currently pregnant? Yes __ No __ If yes, was the pregnancy planned? Yes __ No __

If yes, how many weeks gestation are you currently? _____ Due Date:_____

Have you been pregnant in the past 12 months? Yes __ No __

If yes, did the pregnancy result in a live birth? Yes __ No __ If yes, how old is your child now?____

If you have been pregnant or given birth to a baby in the past 12 months, have you or are you currently experiencing any intrusive thoughts? If yes, please briefly explain:

_____
_____

Total number of pregnancies: _____ Number of living children: _____

Complications during pregnancy/delivery/postpartum (for any and all pregnancies):

_____
_____

Are you currently breastfeeding? Yes __ No __

Previous history of postpartum depression, anxiety, or other mood disorders? Yes __ No __
If yes, please briefly explain:

_____
_____
_____

Substance Abuse Assessment

History of substance abuse/dependence? If yes, please describe (drug of choice, how much used/consumed, how often used/consumed, participation in treatment, periods of sobriety)

_____
_____
_____

Current Alcohol consumption patterns (how much, how often, how long):

_____
_____
_____

Current Drug use patterns (drug of choice, how much, how often, how long):

_____
_____
_____

Nicotine use patterns (past use: how much, how often, how long, current use: how much, how often, how long):

_____
_____
_____

Caffeine use (how much, how often, for how long):

_____
_____
_____

Family Mental Health and Substance Abuse History (Please indicate who):

Alcohol Abuse: _____
Depression: _____
Other mental illness: _____
Adoption: _____
Suicide: _____
Learning Disability: _____
Domestic Violence: _____
Physical Abuse: _____
Rape/Sexual Assault: _____
Active Combat: _____

Drug Abuse: _____
Anxiety/Panic: _____
Disability: _____
Foster Care: _____
Other deaths: _____
Health Problems: _____
Divorce/Separation: _____
Sexual Abuse: _____
Imprisonment: _____
Other: _____

Trauma/Abuse Assessment

Have you been the victim, perpetrator, or witness of:

Physical Abuse: Yes __ No __
Emotional Abuse: Yes __ No __
Neglect: Yes __ No __
Domestic Violence: Yes __ No __
Crime: Yes __ No __
Rape/Assault: Yes __ No __
Sexual Abuse: Yes __ No __
Childhood losses: Yes __ No __
Natural Disasters: Yes __ No __
Other Trauma: Yes __ No __

If you answered "yes" to any of the above, please provide a brief explanation if you are comfortable doing so:

_____
_____
_____

Risk Assessment

Are you currently experiencing thoughts of suicide? Yes __ No __

Have you previously experienced thoughts of suicide? Yes __ No __

Have you previously attempted suicide? Yes __ No __

If yes, please explain (method, date of attempt, resulting hospitalizations, etc):

_____
_____
_____

Are you currently experiencing thoughts or urges to harm someone else? Yes __ No __

Have you previously experienced thoughts or urges to harm someone else? Yes __ No __

Have you previously attempted to physically harm someone else? Yes __ No __

If yes, please describe:

_____
_____
_____