Confidential Client Intake Form

GENERAL INFORMATION

Last Name__________________________________ First ________________________ Middle Initial
____

Preferred Name _____________________________ Birth Date: / / Male _________ Female __________________

Street Address ____ Apt #
___________________ City ____ State
______________________________________ Zip _____________________

Home Phone ( ) _________________________ Work Phone ( ) ___________________ Other ( )
____

Any phone instructions (re: msgs, etc)
____

Email #1: ____ Email #2:
____

Emergency Contact ________________________ Phone ( ) ____________________________ Relationship
____

Parent/Guardian (if under 18)
____

Referred by/How you learned of mc and assoc.:
____

Reason for referral:
____

Reason for choosing mc and assoc.:
____

Religious/Denominational preference:
____

Your church/synagogue: ____ Member?
____

Pastor/Priest/Rabbi:
____

Attendance: Regular ___________ Occasional ___________ Seldom ___________ Never ___________

FAMILY INFORMATION

Relationships: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Cohabiting ___

Parents: Mother: Living ___, age _____. Deceased ___. Father: Living ___, age _____. Deceased ___

Siblings: Number of Brothers [ ]. Number of Sisters [ ]. Only Child ____.

Names and ages of your children:
____

____
____

____ Have any of your children died?
____

Household members not listed above
____

____

EMPLOYMENT/EDUCATION INFORMATION

Full time employee ____ Full time at home ____ Part-time employee ____ Unemployed ____

Place of employment ____ Length of Employment ___________________

Type of work you do ____

Highest level of education completed: High School __________ College degree __________ Graduate degree ___________

Professional Training _________________ Other ____

What is your gross (before taxes) combined household annual income? ____

____

(Over)

What are your concerns/problems that cause you to seek counseling at this time?

____

____

____

Check the following words that describe you at this time:

____ Anger
____ Anxiety
____ Chronic fear
____ Conflicts at work
____ Depression
____ Financial Problems
____ Grief
____ Guilt feelings
____ Health Issues
____ Irrational fears
____ Loneliness
____ Loss of faith in God
____ Loss of hope
____ Loss of meaning in life
____ Loss of work/job
____ Marriage problems
____ Nervousness
____ Rage
____ Relationship to parents
____ Relationship to children
____ Self-esteem
____ Sexual Problems
____ Stress
____ Substance abuse
____ Suicidal feelings
____ Religious doubts
____ Other (list)
____
____
____

What are you hoping to achieve with counseling?____

____

MEDICAL/PSYCHOLOGICAL HISTORY

Name of your physician:____Phone: ( )_______________________

When was your last medical examination? ____

Are you suffering any physical illnesses or symptoms at this time? ____

List major surgeries or illnesses in the last five years:
____

____
____

List current medications:
____

____
____

Are there chemical abuse issues in your family? Yes ____ No ____ If clean/sober, for what length of time? _______________ When? __________________________ Name of helping agency: ____

Have you received psychotherapy or counseling in the past year? Yes ____ No ____ When? _________________________ Name of treating therapist: _____________________________________ Where? _______________________________________ Type of problem: ____ Make a check mark if you would answer "yes" to any of these questions:

___ Do you have thoughts of harming yourself or others?

___ Are thoughts of harming yourself or others a frequent occurrence?

___ Do you dwell on these thoughts and wonder if you can control them?

___ Have you sought professional help because of these thoughts or feelings?

PAYMENT METHOD

Party responsible for payment, if other than client: Name: ____

Address: __________________________________ Phone: (   )_____________________ Agreed hourly fee $______________

____ ____________________________________

Client's Signature Date

____ ____________________________________

Therapist's Signature Date