

## Counseling Intake Form

Client's Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Primary Reason(s) for seeking services \_\_\_\_\_

### Employment

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:

_____	Living with you? Yes No	age: _____
_____	Living with you? Yes No	age: _____
_____	Living with you? Yes No	age: _____

### 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 annoyed by friends or relatives criticizing your drinking or 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: \_\_\_\_\_

<b>Current Medications</b>	<b>Dose</b>	<b>Frequency</b>	<b>Purpose</b>	<b>Side effects</b>
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**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 \_\_\_\_\_