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Confidential Client Intake Summary

Date: ____________________

Name: ____________________

Address: ____________________

City/Zip Code: ____________________

Email ____________________

Phone:__________ Age: _____ Date of birth: _________

Insurance Company on Card: ____________________

Insurance Member ID#: ____________________

Group# on Card: __________ Ins. Start Date __________

Name/DOB of Primary Insurance Holder____________________

Employer (or school, if student) ____________________

Occupation____________________

Relationship Status: __Single __Married __Divorced __Widowed

If separated, how long had you been together: __________

If married, how long have you been married: __________

Current Household Family: Do you have children? __________

Names / Age ____________________

____

Others living in home: name, relationship__________

____

How many times have you been married? __________

Brief description of why you're seeking counseling: __________

____

Counseling history: approximately how many visits with a therapist?

__none __1 - 10 __11- 20 __1 year or more __2 years or more

Current medications/dosage: __________

____

Previous medications, dosages, dates, why stopped __________

____

Relationship to Your Parents __Biological __Adopted __Step-child

Mothers Age: __________ Father's Age: __________

Number of Brothers: __________ Number of sisters: __________

Briefly describe your relationship with your father:__________

____

Briefly describe your relationship with your mother:__________

____

List family members with mental health past: __________

____

History of trauma or abuse

Neglect/Physical abuse/Sexual abuse __________

____

Rape or assault ____________________

Accidents/natural disasters/childhood losses: __________

____

Medical history:

Do you have any significant health/medical issues? __Yes __No

If yes what is/are the health issue(s) and are you limited in any way?

____

____

Abuse history: Have you ever been physically, emotionally, or sexually abused? __Yes __No. If yes, briefly explain (who, what and when):

____

____

Do you have people that you can turn to for support? Yes___ No___

If yes, who? ____________________

What do you hope to achieve or accomplish through counseling?

____

What have you tried that has been helpful? __________

What current issues or problems do you hope to deal with initially?

____

Areas of Concern or Stress: (use an x for current concerns; circle past concerns) __Personal/Relational __Anxiety/worry __Stress

__Panic attacks __Fear __Restlessness __Anger __Frustration

__Confusion __Shyness __Feeling inadequate __Disorganized

__Difficulty making decision __Loneliness __Guilt __Shame

__General unhappiness __Depression __Grief __Crying spells

__Boredom __Mood swings __Suicidal thoughts __Headaches

___Thoughts of hurting others ___Unwanted thoughts/rituals

__Problems at work __Relationship problems __Aches or pains

__Concern about sexual identity/preference __Financial concerns

__Concern about sexual function __Low energy __Nightmares

___Memory lapses, blank periods ___Unable to concentrate

__Abdominal problems __Fatigue __Unwanted memories or images

___Cutting, burning or other self-harm ___Sudden impulses

__Difficulty coping with daily demands __Difficulty trusting others

__Secrets I'm afraid to tell anyone __Physical problems or pain

__Disturbing fears I think about __Communication difficulties

__Inability to stop doing certain things __Peculiar or wierd experiences

__Hearing voices/things others don't hear __Depending too much on others

__Feeling different from others __Alcohol or drug abuse problem

__Restrict food __Binge/purge __Excessive means to control weight

Religious / Spiritual Background:

Affiliated with any church/religion growing up? ___Yes ___No

If yes, what church or religion?____________________

Are you currently affiliated or attending a church/religion now?

__Yes __No If yes, what church/religion? __________

Describe your religious upbringing? __________

____