Confidential Client Intake Summary

Kimberly Acheson
MSW, LCSW
License #10560

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? _____
_____