Clark Counseling & Consulting, Inc

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Intake Form

General Information

Client's Name: _____ Today's Date: _____

DOB: _____ Gender: _____

If client is a minor, name of guardian:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ May I leave a message on voicemail? ☐ Yes ☐ NO

Alternate Phone Number: _____ May I leave a message on voicemail? ☐ Yes ☐ NO

Email Address: _____

Emergency contact #1: Name: _____ Phone Number: _____

Who referred you to my services?:_____

Relational Information

Marital status (Please circle): Single Engaged Married Divorced Separated Widowed Significant Other/Partner

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse/partner: _____ Spouse's/Partner's age: _____

Spouse's/Partner's Occupation: _____

Please provide a brief description of your spouse / significant other (e.g., angry, controlling, outgoing, supportive): _____

_____

Please check the family structure that best describes your home: ☐ Biological Family ☐ Stepfamily

☐ Single parent family ☐ Other (Please describe): _____

Please list children, including step, adopted and foster children, as well as, all other persons living in your household (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Abortions

☐ Gambling ☐ Drug/Alcohol Addiction ☐ Trauma ☐ Domestic Violence

☐ Religious Upbringing ☐ Major Losses ☐ Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

What are your religious/spiritual beliefs?:_____

How important are they?_____

Employment / Education

Employer/School Name: _____ Current Grade: _____

Occupation: _____ Highest Grade Completed: _____

Counseling History

Please state a brief description of primary concern and main reason for seeking counseling:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you previously been in counseling? ☐ Yes ☐ No

Name of Therapist/Program	Inpatient or Outpatient	Issues Addressed	Dates

Any past suicidal thoughts?: ☐ Yes ☐ No If Yes, when?:_____

Outcome? (Hospitalization? etc):_____

Any current suicidal thoughts? ☐ Yes ☐ No Do you have a plan?:_____

Method?:_____ Additional suicidal Information: _____

_____

Any homicidal ideations?: ☐ Yes ☐ No

Are you on any psychotropic medications? ☐ Yes ☐ No List medications: _____

_____

Who prescribes medication? _____

Any family history of mental history? ☐ Yes ☐ No Describe: _____

_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

☐ Aggression	☐ Eating disorder	☐ Loss of control	☐ Sexual addiction
☐ Alcohol Use / Dependence	☐ Elevated mood	☐ Low self-esteem	☐ Sexual difficulties
☐ Anger	☐ Emotional Abuse	☐ Marital problems	☐ Sleeping problems
☐ Antisocial behavior	☐ Fatigue	☐ Memory impairment	☐ Stress
☐ Anxiety	☐ Gambling	☐ Mood shifts	☐ Suicidal thoughts
☐ Apathy	☐ Grief / Loss	☐ Obsessive thoughts	☐ Thoughts disorganized
☐ Avoiding people	☐ Gender identity	☐ Panic attacks	☐ Trauma
☐ Chest pain	☐ Hallucinations	☐ Phobias/fears	☐ Unwanted memories
☐ Codependence	☐ Hearing voices	☐ Physical Abuse	☐ Verbal abuse
☐ Compulsive Behaviors	☐ Heart palpitations	☐ Poor concentration	☐ Violence
☐ Depression	☐ Hopelessness	☐ Racing thoughts	☐ Withdrawing
☐ Disorientation / Indecisiveness	☐ Impulsivity	☐ Recurring thoughts	☐ Worthlessness
☐ Distractibility	☐ Irritability	☐ Relational issues	☐ Work Issues
☐ Divorce	☐ Isolation / Loneliness	☐ Seeing things others don't	☐ Worrying
☐ Drug Use / Dependence	☐ Loss of appetite	☐ Sexual abuse	☐ Other (specify):

_____

Medical History

Name of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

Substance Abuse History

Have you or others had concerns about your use of alcohol or other drugs? ☐ Yes ☐ No

Have you ever tried to control your drinking or drug use? ☐ Yes ☐ No

Do you classify yourself as an alcoholic or addict? ☐ Yes ☐ No

If yes, what is your drug of choice? _____

Have you ever had treatment for alcohol/drugs? ☐ Yes ☐ No

If yes, where and when? _____

Chemical Type	Age of Onset	Age of Regular Use	Frequency, amount of use, type, method	Last Use
Alcohol Beer, Wine, Liquor				
Cocaine Crack				
Cannabinoids Marijuana, Hash				
Amphetamines Crystal Meth, Crank, Speed, Ice, Diet Pills, Benzedrine, Dexedrine, Ritaline, Ecstasy, Methedrine				
Hallucinogens PCP, LSD, STP, Mescaline, Mushrooms, Peyote, Acid, Ketamone				
Sedatives Downers, Quaaludes, GHB **Sleeping Pills** Ambien, Seconal **Tranquilizers** Mellaril, Thorazine, Haldol				
Benzodiazepines Valium, Librium, Xanax, Ativan, Tranxene, Klonopin, Serax, Centrax				
Opiates Heroin, Demerol, Codeine, Methadone, Morphine, Dilaudid, Percodan, Darvon, Lortab, Opium, Percocet, Oxycontin, Soma, Vicodin, Hydrocodone				
Inhalants Gasoline, Glue, Freon				