CONFIDENTIAL CLIENT INTAKE SUMMARY

Last Name: ________________________ First Name: ________________________ Date:____________

Address: ____________________________ City: __________________ State__________ Zip: ___________

I cannot guarantee confidentiality when you and I are communicating via cell phone, cordless phone, fax, email, mail or computer. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools.

Home Phone: _____-________-_________ May we leave a message at this number? ☐ Yes ☐ No

Cell Phone: ______-________-__________ May we leave a message at this number? ☐ Yes ☐ No

Email Address: _______________________ May we leave a message at this address? ☐ Yes ☐ No

Birthdate: _______-________-___________ SSN: ________-_________-___________

Relationship Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Partnered
- ☐ Widowed

Student Status:
- ☐ Not a student
- ☐ Full-time
- ☐ Part-time
- ☐ School Name: ___________

Employment Status:
- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Not-employed
- ☐ Retired
- ☐ Active Military Duty
- ☐ Unknown
- ☐ Other: __________________
- ☐ Employed By: __________________________
- ☐ Occupation: ____________________________

How You Heard About Us:
- ☐ Chiropractor
- ☐ Colleague
- ☐ EAP Provider
- ☐ Family Member
- ☐ Friend
- ☐ Physician
- ☐ Psychology Today
- ☐ School
- ☐ Self
- ☐ Spouse
- ☐ Unknown

Send E-statements to review your account online? ☐ Yes ☐ No
Email Appointment Reminders? ☐ Yes ☐ No
Text Appointment Reminders? ☐ Yes ☐ No
Appointment Reminder Number _______-_________-_________
Emergency Contact: _____________________ Relationship: _______________ Phone: ______-_______-_______

Counseling goals and needs

(If you need more space, please use the back of this form)

Brief description of why you're seeking counseling at this time: ____

____

____

In what ways has this interfered with your daily functioning? ____

____

What do you see as your strengths? ____

What would you like to change and achieve through counseling? _______________________________________

____

What things have you done to try and address this issue?

____

Psychosocial and Medical History Assessment

Social/Family Background

Please briefly describe your current living arrangements: ____

____

Please briefly describe your current relationship status: ____

____

Do you have children? If so, please list name(s), age(s), and any other pertinent details: ____________________

____

Who/what are your sources of support? ____

____

Educational/Occupational Background

What is your education history and highest level completed?____

____

Any learning problems or learning disabilities? ____

What is your occupation and how long have you been employed in that position? ___________________________

____

Are you currently experiencing any impairment in educational or occupational functioning? _________________

____

Cultural Background

Raised by/lived with: ____

Place(s) raised: ____

Religious/Spiritual Background: ____

Ethnicity: ____

Cultural Background (traditions, values, practices): ____

Medical and Psychiatric History

Current Medications: ____

Previous Medications: ____

Allergies: ____

Relevant medical conditions: ____

____

Describe current health problems/concerns: ____

How do you rate your overall health? ☐ Excellent ☐Good ☐Fair ☐Poor

Do you exercise regularly? ☐ Yes ☐ No If yes, what types of exercise? _______________________________

Current Physician: _____________________________ Current Psychiatrist: ________________________________

Previous Outpatient Counseling? ☐ Yes ☐ No
Previous counseling or psychiatrist providers (treatment dates, response to treatment and medication): _________

____

Previous mental health or medical hospitalizations? ☐ Yes ☐ No
If yes, please briefly describe: ____

Any other services you are involved with for your mental health/medical care? ____________________________

Maternal Health History

Are you currently pregnant? Yes________ No_______ If yes, was this pregnancy planned? Yes_____ No______

If yes, how many weeks gestation are you currently? ________________ Estimated Due Date _______________

Have you been pregnant in the last 12 months? Yes______ No_______

If yes, did the pregnancy result in a live birth? Yes___ No____ If yes, how old is your child now? ___________

Have you experienced pregnancy or infant loss? If yes, please briefly explain. ____________________________

____

If you have been pregnant or given birth a baby in the past 12 months, have you or are you currently experiencing any intrusive thoughts? If yes, please briefly explain:

____

____

Total number of pregnancies _____ Number of children _____

Did you experience any complications during your pregnancy/delivery/postpartum? If yes, please briefly explain.

____

____

Did you experience anything you consider traumatic during your pregnancy/birth/postpartum? If yes, please briefly explain. ____

____

Are you currently breastfeeding? ☐ Yes ☐No

Previous history of postpartum depression/anxiety? ☐ Yes ☐ No

Substance Abuse Assessment

Past alcohol consumption patterns (how much, how often, how long): ___________________________________

____

Current Alcohol consumption patterns (how much, how often, how long: ________________________________
____

Past Drug use patterns (how much, how, often, how long): ____

____

Current Drug use patterns (how much, how often, how long): ____

____

Past Nicotine use patterns (how much, how often, how long): ____

Current Nicotine use patterns (how much, how often, how long): _______________________________________

Caffeine use (how much, how often, for how long): ____

FAMILY MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY
(PLEASE INDICATE WHO AND WHEN)

- ☐ Alcohol Abuse______________________________
- ☐ Drug Abuse________________________________
- ☐ Depression________________________________
- ☐ Anxiety/Panic_____________________________
- ☐ Other mental illness________________________
- ☐ Disability_________________________________
- ☐ Adoption_________________________________
- ☐ Foster Care_______________________________
- ☐ Suicide__________________________________
- ☐ Other deaths______________________________
- ☐ Learning Problems_________________________
- ☐ Health Problems___________________________
- ☐ Parental Violence__________________________
- ☐ Divorce/Separation_________________________
- ☐ Physical Abuse____________________________
- ☐ Sexual Abuse_____________________________
- ☐ Rape____________________________________
- ☐ Imprisonment_____________________________
- ☐ Active Combat____________________________
- ☐ Natural Disaster___________________________
- ☐ Work problems____________________________
- ☐ Relationship problems______________________
- ☐ Legal Problems____________________________
- ☐ Financial Problems_________________________

Please check any of the following that apply:

- ☐ Anxiety/Worry
- ☐ Panic attacks
- ☐ Fear
- ☐ Restlessness
- ☐ Anger
- ☐ Frustration
- ☐ Confusion
- ☐ Shyness
- ☐ Feeling inadequate
- ☐ Disorganization
- ☐ Difficulties making decisions
- ☐ Stress
- ☐ Loneliness
- ☐ Guilt
- ☐ Shame
- ☐ General unhappiness
- ☐ Restrict Food
- ☐ Binge/Purge food
- ☐ Depression
- ☐ Grief
- ☐ Crying spells
- ☐ Boredom
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Thoughts of hurting others
- ☐ Unwanted thoughts/rituals
- ☐ Problems at work
- ☐ Relationship problems
- ☐ Concern about sexuality
- ☐ Financial concerns
- ☐ Physical problems/pain
- ☐ Disturbing fears
- ☐ Communication difficulties
- ☐ Depending too much on others
- ☐ Inability to stop doing certain things
- ☐ Memory lapses, blank periods
- ☐ Unable to concentrate
- ☐ Headaches
- ☐ Aches/pains
- ☐ Abdominal problems
- ☐ Fatigue
- ☐ Low energy
- ☐ Poor motivation
- ☐ Nightmares
- ☐ Unwanted memories or images
- ☐ Cutting, burning or other self-harm
- ☐ Sudden impulses
- ☐ Difficulties coping with daily demands
- ☐ Difficulties trusting others
- ☐ Secrets I'm afraid to tell
- ☐ Hearing voices/seeing things others don't see/hear
- ☐ Alcohol or drug abuse problem
- ☐ Changes in sleep patterns
- ☐ Changes in weight (+/-) __________lbs
- ☐ Legal Issues ____________

Risk Assessment

Have you had any previous thoughts or urges to harm yourself or someone else? ☐ Yes ☐ No
If yes, please describe: ____

Have you had any previous suicide attempts? ☐ Yes ☐ No
If yes, please describe (when, method, dates of hospitalizations): ______________________________

Have you had any previous attempts to physically harm someone else or others? ☐ Yes ☐ No
If yes, please describe this incident: ______________________________________

Have you been the victim or perpetrator of any domestically abusive or violent situations? ☐ Yes ☐ No
If yes, please describe: ____

Have you been the victim of any other crimes, natural disasters, or other trauma? ☐ Yes ☐ No
If yes, please describe: ____

Trauma/Abuse Assessment

- ☐ Physical Abuse Who: ___________________
- ☐ Emotional Abuse Who: _________________
- ☐ Sexual Abuse Who: ____________________
- ☐ Rape/Assault Who: _______________________
- ☐ Neglect Who: ___________________________
- ☐ Accidents/childhood losses Who: ____________