Client Intake Form

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Other Names Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by (Name & Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT LIVING SITUATION**

Please note client’s current household:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to client |
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Is there any other information regarding client’s past/current living situation(s) we should be aware about or that you feel impact current functioning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FAMILY HISTORY**

Have there been any major changes in your family in the past few years (e.g. moved, employment changes, deaths, family dynamic): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there any history of mental illness in the client’s family? If yes, please describe: \_\_\_\_\_\_\_\_\_

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Is there any history of substance use in the patience’s family? If yes, please describe: \_\_\_\_\_\_\_\_

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**REASON FOR REFERRAL/CHIEF COMPLAINT**

Describe the problem(s) that brought you here today (please include how long symptoms/concerns have been present in the chart provided below):

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**CURRENT SYMPTOMS AND BEHAVIORS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms and/or Behavioral Concerns** | **When did they start** | **How often are they experienced** | **Problems created from these concerns** |
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Please check all behaviors and symptoms that you consider ***problematic*:**

|  |  |  |
| --- | --- | --- |
|  Acts younger than age |  Guilt |  Picking behaviors |
|  Aggression/fights |  Hair pulling |  Poor memory/confusion |
|  Alcohol/drug use |  Hearing voices |  Racial identity  |
|  Anxiety/worry |  Homicidal thoughts |  Racing thoughts  |
|  Boredom |  Hopelessness |  Sadness/depression  |
|  Change in appetite |  Hyperactivity |  Self-harm behaviors  |
|  Compulsive behavior |  Impaired Judgment |  Sexual behavior  |
|  Computer addiction |  Impulsivity |  Sleep problems  |
|  Crying spells |  Irritability/Anger |  Social discomfort  |
|  Cutting |  Lack of motivation |  Somatic Complaints  |
|  Defiance |  Learning disability |  Spiritual/religious conflicts  |
|  Delusions |  Legal problems |  Stealing  |
|  Destroys property |  Loneliness |  Suicidal thoughts  |
|  Difficulty keeping friends |  Loss of pleasure in activities |  Suicide attempts  |
|  Difficulty making friends |  Low self-worth |  Suspicion/paranoia  |
|  Distractability |  Lying |  Swearing  |
|  Eating problems |  Manipulative behavior |  Thoughts of death  |
|  Elevated mood |  Nightmares |  Visual hallucinations  |
|  Family conflict |  No/few friends |  Wide mood swings  |
|  Fatigue |  Obsessive thoughts |  Withdrawal from people  |
|  Fear away from home |  Oppositional Behavior |  Work/school problems |
|  Fire setting |  Other (specify): |  |
|  Frequent arguments |  Panic attacks |  |
|  Gambling |  Peer conflict |  |
|  Grandiosity |  Peer/sibling conflict |  |
|  Grief |  Phobias |  |

**SUICIDAL THOUGHTS/ATTEMPTS:**

Self-harm (without statement of suicidal intent, this may include thoughts and/or actions):

 Yes No Unable to assess

If yes, describe (include behavior/when started, most recent time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Suicide attempts: Yes No Unable to assess

If yes, describe (include behavior/when started, most recent time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Psychiatric Hospitalization: Yes No Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENTAL HEALTH HISTORY**

Prior mental health records to be requested from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- |
| **Yes** | **No** | **Type of Treatment** | **When (Month/year)** | **Name of Provider/Program** |
|  |  | Outpatient counseling (self-help |  |  |
|  |  | Drug/alcohol treatment |  |  |

Concerns for drug and/or alcohol use: Yes No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TRAUMA**

If not applicable, please leave blank and continue to next question.

Does client have any trauma or exposure to trauma? Yes No Unable to assess

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| --- | --- | --- | --- | --- |
| **Trauma type****(physical, emotional/verbal, sexual, witness to abuse, violence or threats of violence)**  | **Dates** | **Received Therapy for this?** **(Yes or No)** | **When (Month/year)** | **Response at end of therapy** |
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**MEDICATIONS**

If not applicable, please leave blank and continue to next question.

Please list “all” past and present psychotropic medications used, prescribed/non-prescribed.

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| --- | --- | --- | --- | --- | --- |
| **Medication** | **Dosage/****Freq.** | **Reason/Diagnosis** | **Period Taken** | **Effectiveness/Response** | **Side Effects/****Reactions** |
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**PATIENT STRENGTHS**

(to assist in achieving treatment goals)

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**SOCIAL/CULTURAL/SPIRITUAL**

Describe any church, religious or spiritual group or community that your family is currently involved in:

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Have you found spiritual beliefs to be helpful or a hindrance to your family?

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How important are spiritual matters to your family?

 Not at all A little Fairly important Very important

* Is there anything else you feel is important for your therapist to know before beginning?

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