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*:**

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| --- | --- | --- |
| 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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