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Confidential Client Information Intake Form

Date:_____ Referred By:_____

Client Name _____ Sex_____ Age _____ Birthday _____

If client is minor Please give name of Parent or Guardian_____
Social Security # _____
Home Address _____ City_____State_____Zip_____
Home Phone ( )_____ Work Phone ( )_____ Other: _____( )_____

I (We) are seeking outpatient mental health care for ____Myself ____Couple ____ Family ____Child ____ Other

Please describe the problem / issue that brought you to treatment :

_____
_____
_____

What motivated you to deal with this problem / issue at this time:

_____
_____

Family Information:

Current Marital status ( ) Never married ( ) Separated ( ) Divorced ( )Married ( ) Widowed
Number previous Marriages ( ) or Partnerships ( )
Spouse or Co-habitating Partner Name _____ Age _____
How many years together _____ Anniversary date _____
How would you describe your current relationship?_____
_____

Other Family members information (include children or siblings, extended family and Parents or Step Parents)

Name	Relationship	Age	School/Grade/Work/Other	Lives with ?

Education and Employment

Highest level of education completed?_____ Degree?_____
Employer _____Position/Title_____ How Long _____
How do you feel about your job?_____

Spouse/Partner's Employer _____ Position/Title_____ How long _____

If ***Student*** School _____ Grade _____

Have you ever had serious financial problems? _____
Are you aware of any learning disabilities you deal with? Yes ( ) No ( ) Describe: _____
_____
How many times have you moved during your lifetime? _____
Military Service: Yes ( ) No ( ) Branch _____ When?_____

Please list any previous illnesses, accidents or hospitalizations and approximate dates: _____

_____

_____

_____

Have you ever had a serious head injury? Yes ( ) No ( )

Please describe your current physical health: _____

_____

Please list any previous psychiatric/psychological problems and treatment dates (include inpatient or outpatient treatment)

_____

_____

_____

_____

Please list medications previously taken or are currently taking (include dosage & prescribing physician): _____

_____

_____

_____

Name of Primary Care Physician _____ Phone #_____
Date of Last Physical Exam: _____ OB/Gyn Exam _____
Name of Psychiatrist:_____ Phone #_____
Date of last medication evaluation or check? _____
Client's Height_____ Client's Weight _____

During the past 30 days which of the following symptoms have you experienced? (Please circle those which apply)

Sleep Changes	Chronic Pain	Difficulty concentrating
Headaches	Appetite change	Stomach aches
Black-outs	Boredom	Excessive worry
Sex drive changes	Sadness	Isolating from family
Weight loss/ gain	Anxiety/ Nervousness	Isolating from friends
Tiredness	Crying spells	Menstrual changes
Anger or Irritability	Unusual thoughts	Feeling of hopelessness

Have you discussed these symptoms with your primary physician? Yes ( ) No ( )

Have you ever had difficulty with your diet or weight? Yes ( ) No ( ) Diet pills? Yes ( ) No ( )
How often do you exercise? _____

Have you ever considered suicide? Yes ( ) No ( ) Latest thoughts occurred: _____
Do you currently feel that you could hurt someone seriously or kill someone? Yes ( ) No ( )
Have you seriously hurt someone in the past on purpose? Yes ( ) No ( )

Have other family members, immediate or extended family, ever received mental health services? Yes ( ) No ( ) Please describe: _____

_____

_____

_____

Any Family history of problems with____Alcohol ____Drugs ____Sexual Abuse ____Emotional Abuse ____Physical Abuse
____Domestic Violence _____Legal system ____Other: Please describe _____

_____

_____

_____

_____

Alcohol and Drug Usage

Please check as many as apply	NEVER	IN Past	Past Six (6) Months
Anti-Depressants (Prozac, Zoloft, Elavil, Tofranil, Pamelor, Norpramine, Desyrel, Other)	☐	☐	☐
Psychotrophics (Lithium, Haldol,Mellaril, Prolixin,Thorazine)	☐	☐	☐
Alcohol (Beer, Wine, Liquor)	☐	☐	☐
Barbiurates ("downers", Amytal, Nembutal, Seconal, Tuinal, others)	☐	☐	☐
Sedatives (Vallum, Xanax, Restoril, Clonipin, Ativan, Dalmane, Tranxene,Halcion, other)	☐	☐	☐
Amphetamines ("uppers", "speed", diet pills)	☐	☐	☐
Cocaine (Crack)	☐	☐	☐
Inhalants (glue, paint, white-out, etc)	☐	☐	☐
Marijuana (Hash)	☐	☐	☐
Hallucinogens (LSD, "Acid", STP, Mescaline, PCP, "angel dust", Ecstasy, etc)	☐	☐	☐

Nicotine Yes ( ) No ( ) How many packs per day? _____ How long smoked? _____

Caffeine Yes ( ) No ( ) How many sodas/coffee/tea per day? _____ Chocolate? _____

In your opinion do/did any of your family members have a problem with alcohol or drugs (including prescription drugs) ?
Yes ( ) No ( ) If Yes, Who? and please explain : _____
_____
_____

Explain marital problems from drinking or drug use _____
_____
_____

Explain job problems from drinking or drug use: _____
_____
_____

Do you feel you are a normal drinker? Yes ( ) No ( ) Approximate weekly use _____
Have you ever used alcohol or drugs to escape from worries or troubles? Yes ( ) No ( )
Have you ever hidden your use from others? Yes ( ) No ( )
Have you ever experienced shakes or black outs from your alcohol or drug use? Yes ( ) No ( )
Have you ever attended AA, NA, or CA? Yes ( ) No ( )
Have you ever worked with a sponsor from any of these organizations? Yes ( ) No ( )

Any other alcohol or drug history you would like me to be aware of _____
_____
_____
_____
_____

Religious/Spiritual Afiliation

Growing up _____

Today _____

Are you actively involved ? Yes ( ) No ( )
Other comments: _____
_____
_____

Other Personal Information
What are your social, recreational, sports, hobbies and or interests _____
_____
_____
_____

Please list your strengths _____
_____
_____
_____

Please circle which best describes:

Family Relationships	Supportive	Problematic	Non-existent
Friendships	Supportive	Problematic	Non-existent

How many siblings do you have? _____ Half-siblings? _____ Step-siblings? _____

Please write any other important facts or information about your relationships with you family, friends or yourself that you would like this therapist to be aware of Include past/present emotional, physical, sexual abuse, divorces, deaths or other types of losses or traumas in your life experience _____
_____
_____
_____
_____
_____
_____

For additional comments please use this space or back of sheets if necessary

In case of Emergency, Please give contact Name _____
Relationship to you: _____
Phone # ( ) _____ or ( ) _____
Always remember to dial 911 for your first line of help in an emergency

The above information is true to the best of my knowledge: _____
Signature of Client, Parent or Guardian
Date _____