CLIENT INTAKE INFORMATION FORM

The information requested in this form will be kept confidential, and will help your counselor to assist you.
Please fill out the form as completely as you can.

GENERAL INFORMATION **Today's Date**_____

Last Name _____ Middle Initial ___First Name _____

Birth Date ___ / __ /_____ Social Security # ____ - ___ - _____ ❑ Male ❑ Female ❑ _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____ Email _____

Home # ( ) _____ Work # ( ) _____ Mobile # ( ) _____

Guardian/parent (if under 18) _____

Referred by: _____Relationship: _____

Permission to thank referral source: ❑ Yes ❑ No

Reason for choosing this Center _____

Religious/denominational preference _____

Your congregation/church/temple _____

Your racial/ethnic identity: ❑ African-American ❑ Native-American ❑ Asian-American

❑ White/Caucasian ❑ Hispanic ❑ Other_____

EMPLOYMENT/ EDUCATION/ MILITARY INFORMATION

Full time employee_____ Full time at home_____ Part-time employee_____ Unemployed _____

Place of employment _____ Length of Employment _____ Years _____

Type of work you do_____ Are you satisfied?_____

Highest Level of Education Completed: ❑ High School ❑ College degree ❑ Graduate degree

❑ Professional training ❑ Other _____

Military Service ❑ Yes ❑ No Branch _____ Served In Combat ❑ Yes ❑ No

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FAMILY INFORMATION

Relationships: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er) ❑ Cohabiting

Parents. *Mother*: ❑ living, age _____ ❑ Deceased. *Father*: ❑ living, age ____ ❑ Deceased

Siblings. Number of *Brothers* [ ]. Number of *Sisters* [ ]. ❑ Only Child.

List ages of *Brothers* [ ] of *Sisters* [ ].

Names and ages of your *Children*: _____

_____

_____

Annual Family Income:_____ Number of Persons supported by income:_____

PROBLEM DEFINITION

What issues bring you to counseling/therapy today? _____

_____

Rate the level of distress for each symptom over the last six weeks using the scale below:

1= None 2=Mild 3=Moderate 4=Considerate 5=Severe

___Anger
___Anxiety
___Appetite Issues
___Chronic Fear
___Communication Problems
___Concentration Problems
___Conflicts At Work
___Depression
___Domestic Abuse
___Eating Disorder
___Financial
___Grief/Loss
___Guilt

___Hallucinations/Delusions
___Helplessness
___Irrational Fears
___Loneliness
___Loss of Faith in God
___Loss of Hope
___Loss of Meaning in Life
___Loss of work/job
___Marriage Problems
___Memory Problems
___Mood Swings
___Nervousness
___Obsessive Thoughts

___Partner Conflict
___Parenting
___Pornography
___Rage
___Relationship to Children
___Relationship to Parents
___Self Esteem
___Sexual Problems
___Sibling Conflict
___Sleep Issues
___Stress
___Substance Abuse
___Withdrawal

What would you like to see happen as a result of counseling?

_____

MEDICAL/PSYCHOLOGICAL HISTORY

Name and address of your physician: _____

_____

When was your last medical examination? _____

Are you suffering any physical illnesses or symptoms at this time? (please describe)_____

_____

List major surgeries or illnesses in the last five years: _____

_____

List current medications including dosage, reason, date started and prescriber: _____

_____

Do you smoke tobacco?_____ Marijuana?_____ How Often?_____

How often do you use alcohol or other drugs per week? _____

Do you use alcohol or drugs to manage stress?_____relax?_____change mood?_____sleep?_____

Think of the occasion that you drank the most in the past month?_____

How much did you drink?_____How many hours did you drink?_____

Is there any history of drug or alcohol abuse in your family? (Please describe)_____
_____

Has any member of your family experienced mental health issues? (Please describe)_____
_____

Have you received psychotherapy or counseling in the past? ❑ Yes ❑ No. When? _____
Name of treating therapist: _____

What was helpful about it?_____

Have you ever thought about hurting yourself? _____ How recently?_____

Have you ever hurt yourself? _____ How recently? _____

Have you ever thought about hurting someone else?_____ How recently? _____

Have you ever tried to hurt someone else? _____ How recently? _____

Have you (now or ever) experienced or witnessed a traumatic event? Briefly describe _____
_____

Have you (now or ever) experienced verbal abuse? _____

Physical abuse? _____ Sexual abuse? _____

Have you ever had any legal incarcerations? _____ Convictions? _____

Have you ever been hospitalized for psychiatric treatment? _____ When? _____ # Times _____

EMERGENCY CONTACT: In case of emergency, I authorize Centus to contact the following person(s):
Name:_____ Relationship:_____ Phone: (___)_____

Name:_____ Relationship:_____ Phone: (___)_____

PERMISSION TO CONTACT:
While I understand that the following technologies may not be secure, I give Centus Counseling staff permission to leave voicemail, text messages and/or emails regarding appointments and evaluation of services. No identifying private health information is to be disclosed.

_____ _____
EMAIL ADDRESS PHONE NUMBER

_____ _____
CLIENT'S SIGNATURE DATE

01/18