FAMILY COUNSELING CENTER

Confidential Intake Form

Therapist_____ Referred By_____ Date_____

Client Information

Client Name_____ Age_____ Birth Date _____

Address_____ E-Mail_____

City_____ State_____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____ Religion_____

Occupation_____Employer_____

Education Level_____ Highest Degree_____

Marital Status_____ Name of Spouse/Partner_____

If Client is Under 18

Name of Responsible Adult_____ Date of Birth_____

Address_____Phone_____

Relationship to Client_____ Social Security #_____

Father's Name_____ Date of Birth_____

Home Phone_____ Work Phone_____ Occupation_____

Mother's Name_____ Date of Birth_____

Home Phone_____ Work Phone_____ Occupation_____

If Parents are Divorced---Custody Arrangement_____

Income Range

___0-$15,000 ____$15,000-$25,000 ____$25,000-$40,000 ___$40,000-$60,000

____$60,000-$90,000 ____$90,000 and above

Family Information: List below others that live in the home with the client

Name	Age	Gender	Educational Level	Relationship To Client

Medical History

Family Physician_____ Phone _____

Address_____City_____State_____

Date of last medical exam_____ Reason for visit_____

Are You Now Under Doctor's Care? _____ If yes, Doctor's Name_____

Reason for Doctor's Care_____

List Any Current Medications and Dosages

Medication	Dosage	Physician

Have You Ever Been Hospitalized for a Mental Illness? _____ Describe_____

_____

Any Previous Counseling? _____ If Yes, Name of Therapist_____

When and Number of Sessions_____

Type of Counseling: _____

What Do You Expect To Gain from Counseling? _____

Have You Ever Been Hospitalized for a Physical Illness? _____ Describe_____

_____

Check the problem that most reflects your concern at this time:

_____Couple Relationship Issues	**____Anxiety**	**____Eating Disorder**	**___Grief**
_____Parent/Child Parenting Issue	**____Depression**	**____Impulse Control**	**___Trauma**
_____Substance Abuse/Dependency	**____Abuse, Neglect**	**____Anger Issues**	
_____School Behavior Problems	**____ADHD\ADD**	**____Obsessive/Compulsive**	

Do you eat a well-balanced diet? _____
How often do you exercise? _____
Do you use alcohol? _____ How much? _____
What do you do for fun? _____
Do you consume caffeine? _____ How Much?_____

Have you ever experienced:
Physical Abuse? _____
Verbal Abuse? _____
Sexual Abuse? _____
A Violent Crime?_____

Would you like to integrate religious/spiritual issues during your counseling sessions?_____

Check Any of the Following that Apply to You

	Headaches		**Low Blood Pressure**		**Restlessness**		**Sexual Problems**		**Always Tired**
	Always Sleepy		**Recurrent Dreams**		**Alcoholism**		**Allergy**		**Asthma**
	Weight Gain		**Weight Loss**		**Suicidal Thoughts**		**Anger**		**Helpless feelings**
	Nightmares		**Unable to Relax**		**Hallucinations**		**Gambling**		**No Appetite**
	Dizziness		**Fainting Spells**		**Over-eating**		**Feel Tense**		**Feel Panicky**
	Obsessions		**Depressed**		**Shakes or tremors**		**Nausea**		**Diarrhea**
	Stiffness		**Bedwetting**		**Bingeing**		**Crying Spells**		**Drug Abuse**
	Impulsive		**Irritability**		**Self-mutilation**		**Purging**		**Suspiciousness**
	Mood Changes		**Suspiciousness**		**Frequent Physical Complaints**		**Threatening Behaviors**		**Hopelessness**
	Insomnia		**Frequent Lying**		**Bullying**		**Constipation**		