Client Intake Form

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Registered Addiction Specialist

Today's Date: _____

Name of person filling out this form:_____ Relationship to client:_____

Client's Name:_____ Birthdate:_____ Age:_____

Address:_____ Home Telephone:_____

Town/Zip____ _____Alternate phone:_____

Is it okay to leave a message on these phone numbers? _____

With whom do you live:_____ Relationship to you:_____

Race/ethnicity:_____ Religious Affiliation:_____

Educational background:_____

Military History:_____

Profession/Occupation:_____

Marital Status/Relationship Status:_____

Years together:_____ Number of previous marriages:_____

Your children (B=Biological, A= Adopted, S= Step, F= Foster)

Name:_____ Age:_____ Type:_____ Custody? _____

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Name: _____Age:_____ Type:_____ Custody?_____

Your Family

Were you adopted?_____ Were you ever in foster care?_____

Please list how many sibling you had, their genders and current ages and relation to you:
(B= Biological, S= Step, H= Half, A= Adopted)

_____

_____

_____

Are your parents still living? (circle): Mother: yes no Father: yes no

Are your parents still married? _____ Are they divorced?_____ Age at Divorce?_____

Briefly describe your mother:_____

Briefly describe your father:_____

Health History

Are you presently taking prescribed medication? If so, name of medication, dose, frequency:_____

_____

Please list any medication, prescribed or OTC(with dose and frequency) that you've taken in the recent past:

_____

Your last physical examination date:_____

Are you presently under the care of a physician?Describe: _____

Name and phone number of physician:_____

Do you have a history of health problems or disease?_____ If yes, please explain_____

_____

Do you have a present health issue of concern?_____

Please use additional information page or back of page to elaborate on any question if you need more room.

Substance Use (please include age a 1st use, last use, way substance was used, average amount used in past 30 days, average amount used at time of highest usage and any other relevant information)

Alcohol_____

Marijuana_____

Methamphetamine_____

Stimulant drugs, any other_____

Cocaine/Crack_____

Heroin_____

Oxycodone/Percocet/Other Opiates_____

Hallucinogens(LSD, mushrooms, X, etc)_____

Xanax/Depressants_____

Sleeping aids_____

Other Prescription drugs used recreationally_____

Nicotine_____

Caffeinated drinks (soft drinks, energy drinks, coffee) _____

Any other substance not mentioned here? _____

Are you concerned about your present drug or alcohol use? _____

Are you or have you ever been in a substance abuse recovery program? If so please explain: _____

_____

Other Assessment Questions

Have you ever been a victim or perpetrator of domestic violence? Is so please describe: _____

_____

Are you currently concerned for your safety or the safety of your children? _____

Have you ever been to a therapist/counselor before? If so, when and whom?_____

_____

Have you ever been hospitalized for psychological reasons?_____

Have you ever been diagnosed with a mental disorder?_____

Have you ever harmed yourself or attempted suicide? If yes, please explain: _____

_____

Have you ever been arrested for a crime? Please explain: _____

_____Are you currently on probation or parole?_____

Describe your sleeping patterns:_____

Describe any types of physical exercise/movement you participate in: _____

_____

Describe your present job (i.e. stressful, enjoyable, etc):_____

_____ How many hours weekly do you work? _____

Describe your present social support system, friendship network or other supportive relationships:_____

_____

What do you enjoy doing most in your present life?_____

Have any of these conditions occurred? (indicate X =previously C= currently):

____ aggression	_____ self abusive behaviors	_____ eating disorder
_____ excessive anger	_____ persistent fears, anxiety	_____ anxiety attacks
_____ nail biting	_____ learning disabilities	_____ sleep difficulties
_____ nail biting	_____ learning disabilities	_____ emotional abuse
_____ physical abuse	_____ sexual abuse	_____ depression
_____ loss of a loved one	_____ low self-esteem	_____ excessive guilt or shame
_____ excessive shyness	_____ night terrors	_____ suicide attempts
_____ preoccupation w/sex	_____ sexually active before age 13	_____ unhappy childhood
_____ sexual difficulties	_____ infertility	_____ head injury
_____ hyperactivity	_____ difficulty w/social relationships	
_____ attention deficit	_____ compulsive spending	_____ delinquency

Other item not mentioned here:_____

What is causing you the most stress or concern at this time?_____

_____

What are your strengths or internal resources that you use to cope with life stressors (if difficult to answer, consider what others notice and appreciate about you): _____

What do you feel are your greatest accomplishments?_____

Please explain what event led you to seek counseling?_____

What results do you expect from counseling?_____

Emergency Contact Information

Name:_____ Address:_____

Phone:_____ Alternate Phone:_____

Relationship to you:_____

How did you hear of Alice Petty-Hannum, MFT?_____

Please write any additional information you feel is important on the back of this page if needed.

Thank you for completing this form. It is important and will assist me in designing an individual treatment plan for you. Please feel free to ask any questions you may have when we meet for our appointment.

Client signature:_____ Date:_____

Parent/Guardian signature (if client is a minor):_____