R³ Counseling & Consulting Services

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Date: _____/_____/_____

Name: _____ DOB: ____/____/____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Okay to leave messages? □ Yes □ No

Email Address: _____

Ethnicity: □ American Indian or Alaskan Native □ Asian American □ Black/African American
□ Hispanic □ Multiracial □ Pacific Islander □ White □ Other _____

US Citizen? □ Yes □ No If no, immigration status: _____

Marital Status: □ Single □ Cohabitating □ Married □ Separated □ Divorced □ Dating

Schooling (highest level completed):

□ Elementary school □ High School □ College □ Graduate School □ Trade School □ GED

Persons living with you:

Name	Age	Relationship

Who referred you: _____

Current Concerns

Briefly describe your current difficulties:

_____

_____

_____

How long has this problem been of concern to you?

_____

What seems to help this problem?

_____

What seems to make this problem worse?

_____

Have any other family members had similar problems? □ Yes □ No If yes, whom?

_____

Have you received an evaluation or treatment for the current problem or similar problem?

□ Yes □ No If yes, when and with whom? _____

Describe any major event(s) that might be related to the problem (e.g., death, divorce, abuse, etc.)

_____

_____

_____

_____

_____

_____

Treatment History

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
□ Yes □ No

Have you had previous psychotherapy? □ Yes □ No If yes, please explain:

_____

_____

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□ Yes □ No

If yes, please list: _____

Prescribed by: _____

Health Information

Do you currently have a primary physician? □ Yes □ No

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? □ Yes □ No

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.:

_____

_____

Are you currently on medication to manage a physical health concern? If yes, please list:

_____

_____

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams
□ other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Restricting

Have you experienced significant weight change in the last 2 months? □ Yes □ No

Do you drink alcohol? □ Yes □ No If yes, how often?

□ daily □ at least once 1-2 week □ more than 3 times a week □ monthly

In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

How often do you engage recreational drug use? □ daily □ weekly □ monthly □ rarely □ never

Do you smoke cigarettes or use other tobacco products? □ Yes □ No If yes, how often

_____

Have you had suicidal thoughts recently?

□ frequently □ sometimes □ rarely □ never

Have you had them in the past?

□ frequently □ sometimes □ rarely □ never

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	Yes / No
Extreme anxiety	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Unexplained losses of time	Yes / No
Unexplained memory lapses	Yes / No
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

Occupational Information

Are you currently employed? □ Yes □ No

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

Religious/Spiritual Information

Do you consider yourself to be spiritual/religious? □ Yes □ No

If yes, what is your faith? _____

Briefly describe the role religion/spirituality play in your life: _____

_____

_____

_____

Family Mental History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/Substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	
ADHD/ADD	Yes / No	

Social History

Are you currently in a romantic relationship? □ Yes □ No

If yes, how long have you been in this relationship? _____

Do you have trouble in your relationship with others? □ Yes □ No

How many intimate relationships have you had that lasted more than 3 months? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

Have you served in the military?

□ Yes □ No If yes, details: (highest rank, special honors, duties, discharge status)

_____

_____

Have you ever been in trouble with the law?

□ Yes □ No If yes, describe:

_____

_____

List names and ages of children (if different than people living with you):

_____

_____

_____

_____

Other Information

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

Additional Comments

_____

Client Signature Date

_____

Kimberly Mason, Ph.D., LPC-S, NCC Signature Date