Elizabeth Nelson MA, LCPC
Clinically Licensed Counselor

CLIENT INTAKE FORM

Please complete this form and bring it with you to your initial intake session.
If you have any questions, I will be glad to answer them during your intake.
All information is completely confidential.

Personal Information *Today's date*_____

Name:_____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age:____

Marital Status: □ Never married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children:____ Ages:_____

Current Address:

_____

_____

Home Phone:_____ May I leave a message? □ Yes □ No

Cell/other:_____ May I leave a message? □ Yes □ No

Email:_____ May I email you? □ Yes □ No

Referred by:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No

Reason for change:

_____

Have you ever been prescribed a psychiatric prescription medication? □ Yes □ No

If yes, please list:

1._____Side effects:_____

2._____Side effects:_____

General Health and Mental Health Information

How is your physical health at the present time?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

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

Please list all medications you are currently taking:

1._____Side effects:_____

2._____Side effects:_____

3._____Side effects:_____

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

If yes: □ Sleep too much □ Sleep too little □ Poor quality □ Disturbing dreams

Other:_____

How many hours sleep do you average in night? _____

How many times per week do you exercise? _____days _____minutes/hours

What is your choice of exercise? _____

Are there any changes or difficulties with your eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced a weight change in the last two months? □ Yes □ No

Have you been diagnosed with an Eating Disorder? □ Yes □ No

If yes, what is the diagnosis?_____

Do you consume alcohol regularly? □ Yes □ No

How much per day? _____

In one month, how many times do you have 4 or more drinks in a 24-hour period?_____

Do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

If yes, what substance are you taking? _____

Have you felt depressed recently? □ Yes □ No

If yes, for how long?_____

List your symptoms of depression. _____

_____

Have you had any suicidal thoughts recently? □ Yes □ No
If yes: □ Frequently □ Sometimes □ Rarely
Have you had suicidal thoughts in your past? □ Yes □ No
If yes, how long ago?_____ How often? □ Frequently □ Sometimes □ Rarely
Have you ever made plans to commit suicide?
Do you engage in any form of self-harm? □ Yes □ No
If yes, please list _____

Are you currently in a romantic relationship? □ Yes □ No
If yes, how long have you been in this relationship? _____
On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____
How would describe the relationship? _____
_____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, loss, etc.)?
_____

What important things about you, your marriage or family, would be helpful for me, your counselor, to know (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)?

_____

Quick Check

Check the boxes of the symptoms you have experienced.

□ Extreme depressed mood	□ Mood swings	□ Rapid speech	□ Extreme anxiety
□ Panic attacks	□ Phobias	□ Disturbed sleep	□ Hallucinations
□ Repetitive thoughts	□ Anxiety	□ Time loss	□ Repetitive behaviors
□ Homicidal thoughts	□ Suicide attempts	□ Trouble planning	□ Relationship trouble
□ Aggression	□ Anger	□ Addictive Behavior	□ Anhedonia
□ Bereavement	□ Dissociation	□ Hopelessness	□ Helplessness
□ PTSD	□ Pornography	□ Sexual Addiction	□ Tearful
□ Worry	□ Sexual Concerns	□ Bingeing	□ Purging
□ Restricting Intake	□ Depression	□ Impulsiveness	□ Compulsions
□ Memory lapse	□ Alcohol and/or substance abuse		□ Eating disorder

Have you been abused sexually, emotionally or physically? Please describe briefly.

_____

_____

Are you now, or have you ever been involved in any sexual behaviors which have been problematic for yourself or someone else? No Yes
If yes, please explain:

_____

Occupational Information

Are you currently employed? □ Yes □ No

If yes, who is your employer? _____, Position_____

Are you happy in your current position? □ Yes □ No

Are you fulfilled in your current position? □ Yes □ No

Does your work make you stressed? □ Yes □ No

If yes, what are your work-related stressors?

_____

When do you rest or attend to self-care and please describe:

_____

Religious/Spiritual Information

Do you practice a religion? □ Yes □ No If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? □ Yes □ No

How does your spirituality inform your life? _____

_____

Do you want your faith to be included in your counseling sessions? How? _____

***Describe family atmosphere while growing up by circling most accurate*:**

affectionate	angry	cold	rigid	cooperative
supportive	neglectful	distant	frightening	overprotective
trusting	competitive	close	stable	accepting
loving	abusive	chaotic	nurturing	expressive

Other:

Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

Issue			*Family Member*
Depression	□ Yes	□ No	_____
Anxiety Disorder	□ Yes	□ No	_____
Bipolar Disorder	□ Yes	□ No	_____
Panic Attacks	□ Yes	□ No	_____
Alcohol/Substance Abuse	□ Yes	□ No	_____
Eating Disorder	□ Yes	□ No	_____
Learning Disability	□ Yes	□ No	_____
Trauma History	□ Yes	□ No	_____
Domestic Violence	□ Yes	□ No	_____
Obesity	□ Yes	□ No	_____
Obsessive Compulsive Behavior	□ Yes	□ No	_____
Schizophrenia	□ Yes	□ No	_____
Addiction	□ Yes	□ No	_____
Other	□ Yes	□ No	_____

Other Information

List your strengths/ what you like most about yourself-

_____

_____

List areas you feel you need to develop -

_____

_____

What brings you in today?

_____

_____

What are your goals for therapy? What are you hoping will change by participating in counseling?

_____

_____

_____