



CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Age: _____ Date of Birth: _____

Gender: Male Female Transgender: M to F Transgender: F to M

Home Address: _____

Mailing Address if different than Home: _____

Email Address: _____ May we email you? Yes No

Best Contact Phone number: _____

Emergency Contact Name _____ Relationship _____ Phone _____

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

White/Caucasian African-American Black African Asian-American Asian or Pacific Islander Hispanic-American
Latino/Latin American/Hispanic Arab-/Middle Eastern-American Arab/Middle Eastern Native American
Alaskan Native Multiracial Other

Specify: _____

How much do you identify with your ethnic heritage?

Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list:

Religious preference: _____

Are you currently active in your religion?

Yes Somewhat No

Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process?

Yes No I Don't Know

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____

Hours worked per week: _____ Years with employer: _____

Position: _____

Are you satisfied with your job? Yes No I Don't Know

Highest Educational Degree: _____

Major: _____

Are you a student? Yes No If yes, where are you studying: _____

RELATIONAL HISTORY:

Please indicate your current relationship status:

Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed

Other: _____

Approximately how many significant romantic relationships have you had? _____

How many times have you married? _____

What are the dates of your marriage(s) and divorce(s)? _____

If you are in a romantic relationship, how long have you been in this relationship? _____

If you are married, how long did you know your spouse/partner before marriage? _____

Are you satisfied with your current romantic relationship? Yes No I Don't Know

Do you feel supported by your partner/spouse? Yes No I Don't Know

FAMILY/FRIENDS BACKGROUND:

Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student, 12; partner, M, doctor, 35):

Family Member	Occupation	Age
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Your Family's Religious/Spiritual Background: _____

How much conflict do you currently experience with your family (whether living with you or not)?

None Very little Some Moderate Strong Extreme

Have you experienced any significant death in your family? Yes No

Are you a twin? Yes No

Please list any step-parents _____

How many brothers do you have? _____ Ages of brothers _____

How many sisters do you have? _____ Ages of sisters _____

How many sons do you have? _____ Ages of sons _____

How many daughters do you have? _____ Ages of daughters _____

Has there been any adoption within your family? Yes No

How would you rate the quality of your friendships?

Very Poor Unsatisfactory About Average Good Excellent

Besides family, how many people can you count on right now for friendship/emotional support? _____

How well are you getting along with each of the following persons?
(Choose a number between 1 and 10, with 10 being very well and 1 being very poorly.)

Mother _____ Father _____ Sister(s) _____ Brother(s) _____ Spouse/Partner _____

Female Child(ren) _____ Male Child(ren) _____ Friend(s) _____

PHYSICAL HEALTH:

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

When was your last physical examination? _____

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

Do you have a disability? No Yes Specify:

Are you presently taking any prescribed medication? Yes No

Please list all medications, the reason for which each is prescribed, name of prescribing physician (e.g.: Paxil/ social anxiety/Dr. Joseph):

Name of your primary care physician: _____

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

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

Have you had a significant weight change in the last 2 months? No Yes

Do you have any problems or worries about sexual functioning? No Yes

How many times per week do you exercise? _____ For how long each time? _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank for now)*

Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child

Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse Sexual abuse/assault as an adult

Other Trauma Specify: _____

Have you received counseling here or elsewhere before? Yes No

If yes, where: _____ When: _____ Duration: _____

What was the focus of previous counseling?

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No

If yes, where: _____ When: _____ Duration: _____

What was the focus of the psychiatric treatment?

Were you EVER prescribed psychiatric medications? Yes No

What medications and for what reason?

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: _____

How often are you having thoughts of harming others presently? Frequently Sometimes Rarely Never

How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never

When: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: _____

Have you ever attempted suicide? Yes No Date(s): _____

Have you ever been hospitalized for psychological reasons? Yes No

Date(s): _____

Have any of your family members (parents, grandparents, siblings) had psychological issues? Yes No

If so, please describe: _____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

Do you or does someone else think that you may need to cut down or stop using other drugs?

Yes No Maybe

PROBLEM ANALYSIS:

Briefly describe the problem you most wish help with right now: _____

How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 (not intense) 2 3 4 5 6 (extremely intense)

How much has your current problem interfered with your life in general?

Not at all A little Somewhat Moderately To a great extent

In what ways have you attempted to cope with this problem?

How many counseling sessions do you anticipate needing?

1-3 4-6 7-9 10-12 13-15 16-20 20+

Name: _____

Date: _____

Burns Depression Checklist

Instructions: Indicate how much each of the following 15 symptoms has been bothering you in the past several days.

	0 - Not at all	1 - Somewhat	2 - Moderately	3 - A lot
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look bleak or hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a loser?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability and frustration: Have you been feeling angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a lot about your health?				
15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead?				

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Name: _____

Date: _____

Burns Anxiety Inventory

Instructions: Indicate how much each of the following 33 symptoms has been bothering you in the past several days.

0 - Not at all	1 - Somewhat	2 - Moderately	3 - A lot
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CATEGORY 1: ANXIOUS FEELINGS			
1. Anxiety, nervousness, worry, or fear			
2. Feeling things around you are strange or foggy			
3. Feeling detached from all or part of your body			
4. Sudden unexpected panic spells			
5. Apprehension or a sense of impending doom			
6. Feeling tense, stress, "uptight" or on edge			
CATEGORY 2: ANXIOUS THOUGHTS			
7. Difficulty concentrating			
8. Racing thoughts			
9. Frightening fantasies or daydreams			
10. Feeling on the verge of losing control			
11. Fears of cracking up or going crazy			
12. Fears of fainting or passing out			
13. Fears of illnesses, heart attacks or dying			
14. Fears of looking foolish in front of others			
15. Fears of being alone, isolated or abandoned			
16. Fears of criticism or disapproval			
17. Fears that something terrible will happen			
CATEGORY 3: PHYSICAL SYMPTOMS			
18. Skipping, racing or pounding of the heart			
19. Pain, pressure or tightness in the chest			
20. Tingling or numbness in the toes or fingers			
21. Butterflies or discomfort in the stomach			
22. Constipation or diarrhea			
23. Restlessness or jumpiness			
24. Tight, tense muscles			
25. Sweating not brought on by heat			
26. A lump in the throat			
27. Trembling or shaking			
28. Rubbery or "jelly" legs			
29. Feeling dizzy, lightheaded or off balance			
30. Choking or smothering sensations			
31. Headaches or pains in the neck or back			
32. Hot flashes or cold chills			
33. Feeling tired, weak or easily exhausted			

