Inspiring Change Counseling, LLC

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Licensed Professional Counselor
Nationally Certified Counselor
Distance Credentialed Counselor

CLIENT INTAKE FORM

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 15 minutes prior to your appointment to complete the form in the office.

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

Name of parent/guardian (if you are a minor):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status:
☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____

Local Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____ May I leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( ) _____ May I leave a message? ☐ Yes ☐ No

E-mail: _____ May I email you? ☐ Yes ☐ No

Chief Concern: Please describe the main difficulty that has brought you to see me:

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Your medical care (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your current employer

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Present relationships

How do you get along with your spouse or partner?

How do you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services?

☐ Yes ☐ No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

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If yes, please indicate:

When:

From Whom:

For What:

Results:

Have you ever taken medications for psychiatric or emotional problems? ☐ Yes ☐ No

If yes, please indicate:

When

From Whom:

For What:

Results:

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings

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List of Symptoms (Continued)

insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Family:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Job/school performance:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Friendships:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Financial situation:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

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Physical health:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Mood:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Eating habits:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Sexual functioning:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect Not Applicable

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Substance Use

Do you currently consume alcohol? ☐ Yes ☐ No
If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?_____

Do you have a history of problematic use of alcohol? ☐ Yes ☐ No

Have family members or friends expressed concern about your drinking? ☐ Yes ☐ No

Do you currently use non-prescribed drugs or street drugs? ☐ Yes ☐ No

Do you have a history of problematic use of prescription or non-prescription drugs? ☐ Yes ☐ No

Do you have a family history of alcohol or drug problems? ☐ Yes ☐ No

If yes, please describe:

Other
Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the page if needed.