Client Intake Form

Stephanie R. Frey MAMFC, LPC, LMFT

General Information

Today's Date_______________________________ Social Security Number:________--________--________

Name:____________________________________ Date of Birth:_____--_____--_____ Age:_____________

Home Address:____
(street) (city) (state) (zip)

Home Phone: (_____)_______--__________ Work Phone: (_____)_______--__________

Cell: (_____)_______--__________ Other___________: (_____)_______--__________

*Calls will be discrete, however please indicate *any* restrictions: ______________________________________

Email:____

Marital Status: ❑ Married (duration___________; # of times__________)

Spouse's Name: ______________________________ Spouse's date of birth: _____--_____--_____

❑ Single (duration __________) ❑ Divorced (duration __________) ❑ Widowed (duration __________)

Emergency Contact: Name:________________________ Phone: (_____)_______--_________

Employer(s) Name:____

Employer(s) Address: ____
(street) (city) (state) (zip)

Who referred you to this counselor/office?______________________________________

How did you first become aware of my services?____

Briefly describe your issue / reason(s) for seeking help?____

____

What have you already done to try to solve the issue / reason(s)?_____________________________________

____

Medical & Health Information

Doctor's Name:____________________________________ Phone: (_____)_______--_________

Address: ____
(street) (city) (state) (zip)

Have you ever received psychiatric or psychological help or counsel of any kind before? ❑ Yes ❑ No
If Yes, please explain:____

Please indicate *all* medication(s) (including vitamins, birth control, diet pills, etc.) that **you are currently taking** on a regular basis.

Medication Name	**Reason For Taking**	**Dosage** *(if known)*	**Duration of use**

Please tell me about any health problems you may have experienced in the last twelve (12) months or any ongoing problem(s) in general: ____

____

Please list any medication(s) that you have taken in the past for anxiety, nervousness, depression, or related types of problems:

Medication Name	**When Taken & How Long**	**Degree of Helpfulness**

Please indicate any other important health related information that you feel is necessary:__________________

____

Have you ever been hospitalized in a psychiatric facility? ❑ Yes ❑ No If yes, when, how long, and reason for admission:____

____

____

Do you currently have any suicidal thoughts or feelings? ❑ Yes ❑ No

If Yes, please explain:____

____

____

____

Please indicate any of the following that you have previously had along with the date acquired (all information is kept confidential):

❑AIDS ________
❑Alcohol Abuse or Alcoholism ________
❑Anemia________
❑Anxiety Disorder/Problem ________
❑Asthma________
❑Cancer________
❑Concussion or Head Injury________
❑Chronic/Frequent Colds_________
❑Depression________
❑Diabetes________
❑Drug Abuse or Addiction________
❑Eating Disorder________
❑Eye Trouble________
❑Ear, Nose or Throat Trouble________
❑Epilepsy________
❑Gambling Problem________
❑Heart Trouble ________
❑Hepatitis________
❑High Blood Pressure________
❑Low Blood Pressure________
❑Manic/Bipolar Depression________
❑Panic Attacks ________
❑Phobias/Sever Fears ________
❑Premenstrual Syndrome________
❑Schizophrenia________
❑Sexual Addiction________
❑Sinus/Allergy Problems________
❑Stroke________
❑Stomach or Intestinal Problems________
❑Thyroid Problem ________
❑Ulcers ________
❑Venereal Disease________
❑Other:____________________

Drugs & Alcohol

❑ yes ❑ no In the past year have you consumed alcohol or used drugs more than you meant to?

❑ yes ❑ no Have you ever neglected some of your usual responsibilities because of alcohol or drugs?

❑ yes ❑ no Have you ever wanted to or needed to cut down on your drinking or drug use?

❑ yes ❑ no Has anyone every objected to your drinking or drug use?

❑ yes ❑ no Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

❑ yes ❑ no Have you every used alcohol or drugs to relieve emotional discomfort such as sadness, anger or boredom?

(only to be answered if more than 2 "yes" responses to the above)

What is/are your drug(s) of choice?____

What is or has been you pattern of usage?____

Have you every been actively involved in a 12 Step group and do you have a sponsor?____________________

What is the longest period you have been sober?____

Is there any significant history or current issues?____

Education & Training

Please complete the information below in regards to school, college, training or certificate program(s), as well as any military experience.

Date from/to	School or Branch of Service	Major or Position Held	Degree

General Family Information

Please complete the below information pertaining to family of origin.

Relative/ Relation	Name	Age (or age at death)	Occupation	Known illness (or cause of death)	How do/did you get along?	Three words that describe him/her
Father						
Mother						
Stepfather						
Stepmother						

Please complete the below information as it pertains to your brother(s) or sister(s):

Name	**Age**	**Relationship Now**		
____________________	__________	❑ Close	❑ Distant	❑ Moderate
____________________	__________	❑ Close	❑ Distant	❑ Moderate
____________________	__________	❑ Close	❑ Distant	❑ Moderate
____________________	__________	❑ Close	❑ Distant	❑ Moderate
____________________	__________	❑ Close	❑ Distant	❑ Moderate

Have you ever experienced any of the following?

- ❑ Harsh physical punishment or abuse as a child
- ❑ Sexual advances made toward you as a child
- ❑ Sexual abuse
- ❑ Incest
- ❑ Rape
- ❑ Physical abuse
- ❑ Verbal or emotional abuse as a child or adult

What shocks/trauma did you experience as a child/teen?____

____

Do you know of any family history of:

❑ Alcoholism/Drug Abuse
Who:

❑ Sexual Abuse
Who:

❑ Mental Illness
Who:

❑ Attempted Suicide/Suicides
Who:

❑ Physical Abuse/Emotional Abuse
Who:

❑ Affairs
Who:

❑ Premarital Pregnancies
Who:

Marital /Relationship History

Please complete the below information as it pertains to your marital history.

Spouse's Name	Spouse's age at marriage	Your age at marriage	Your age when divorced/ widowed	Is spouse remarried?
First:				❑ Yes ❑ No
Second:				❑ Yes ❑ No
Third:				❑ Yes ❑ No

Please complete the below information as it pertains to your children.

Name	Current Age	Sex	School	Grade	Previous Marriage? y/n	Other Important Information

Is there any other significant non-marital relationships? ❑ Yes ❑ No If yes, please complete the below:

Name	Person's age when started relationship	Your age when started relationship	Your age when relationship ended	Reasons for ending

Is there another family member, other than yourself, currently seeing a psychiatrist or counselor? ❑ Yes ❑ No

If yes, what family member?____________________ Name of counselor:_______________________________

For what reason:____

Religion & Faith

What was your religious affiliation during childhood and adolescence?_________________________________

What is your current religious affiliation, if any?____

If you attend church, what is your present church?____

Do you currently consider your faith/religion meaningful in your life? ❑ Yes ❑ No If yes, please explain:_____

____

Goals for Treatment

Who are your significant friends/supporters in your life?____

What are your goals for treatment?____

Any other information:____

____

____

____ __________________________

Stephanie R. Frey MAMFC, LPC, LMFT Date