

CLIENT INTAKE INFORMATION FORM

The information requested in this form will be kept confidential and will help your counselor to assist you. Please fill out the form as completely as you can. Use an "X" to indicate your choices.

Write in words or numbers where asked.

General Information

Last Name: _____	First Name: _____	Middle Initial: _____
Birth Date: ___ / ___ / ___	SS#: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address: _____		
City: _____	State: _____	Zip: _____
Home Telephone: () _____	Work Telephone: () _____	e-mail _____
Guardian / Parent (if under 18): _____		
How did you learn about the Center? <input type="checkbox"/> Phone <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Pastor/Church Literature <input type="checkbox"/> Physician <input type="checkbox"/> Employer <input type="checkbox"/> Newspaper <input type="checkbox"/> EAP <input type="checkbox"/> Internet <input type="checkbox"/> Social Media Website <input type="checkbox"/> Friends/Acquaintances <input type="checkbox"/> Family <input type="checkbox"/> Other		
Who referred you to the Center? _____		
May we send a thank you letter to that person as a courtesy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for choosing this Center: _____		
Religious/denominational preference: _____		
Your racial / ethnic identity: <input type="checkbox"/> African-American <input type="checkbox"/> Native-American <input type="checkbox"/> Asian-American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		

Employment / Education Information

Full-time employee _____	Part-time employee _____	Self employed _____	Unemployed _____
Place of employment: _____			
Type of work you do: _____			
Length of time employed at this position: _____			
Degree of satisfaction with current employment: <input type="checkbox"/> Very Satisfied <input type="checkbox"/> Satisfied <input type="checkbox"/> Dissatisfied			
Is there any history of work-related difficulties? If so, describe: _____ _____			
Highest level of education completed: <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Professional Training <input type="checkbox"/> Other: _____			

Family Information

Relationships: Single Engaged Married Separated Divorced Widow(er) Cohabiting

Parents: *Mother*: Living, age _____ Deceased *Father*: Living, age _____ Deceased

Sibling: Number of *Brothers* _____ Number of *Sisters* _____ Only Child

List ages of *brothers* [_____] of *sisters* [_____]

Names and ages of your *Children*: _____

Have any of your children died? _____ If so, When: _____

Problem Definition

What is your reason for seeking help now? _____

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

- Anxiety
- Grief
- Depression
- Irrational fears
- Nervousness
- Loneliness
- Anger
- Marriage problems
- Sexual concerns
- Loss of work/job

- Self esteem
- Stress
- Substance abuse
- Chronic fear
- Guilt feelings
- Suicidal feelings
- Loss of hope
- Rage
- Relationship with parents
- Relationship with children

- Loss of meaning in life
- Loss of faith in God
- Conflicts at work
- Religious doubts
- Other (list):

Make a check mark if any of these statements are true.

- I have thoughts of harming myself or others.
- Thoughts of harming myself or others is a frequent occurrence.
- I dwell on these thoughts and wonder if I can control them.
- I Have sought professional help because of these thoughts or feelings.

