Client Psychosocial Intake Form

GENERAL INFORMATION

Date: _____ Referred By: _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

Name You Prefer: _____ Age: _____ Date of Birth: _____

Parent(s) Name(s), for Minor Client: _____

Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other: _____ Sex: ☐ Male ☐ Female

CONTACT INFORMATION

Address: _____ Suite or Apt. #: _____

City: _____ State: _____ Zip Code: _____ May we send mail here: ☐ Yes ☐ No

Home Phone: _____ May we leave a message here: ☐ Yes ☐ No

Mobile Phone: _____ May we leave a message here: ☐ Yes ☐ No

Email Address: _____ May we leave a message here: ☐ Yes ☐ No

EMERGENCY CONTACT

Name: _____ Relationship to You: _____

Mobile Phone: _____ Home Phone: _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Annual Salary: ☐ $0 to $10,000 ☐ $10, 001 to $20, 000 ☐ $20, 001 to $40, 000 ☐ $40, 001 to $50, 000
☐ $50, 001 to $60, 000 ☐ $60, 001 to $80, 000 ☐ $80, 001 to $100, 000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of High School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ AA College: ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Master's Degree ☐ Doctorate Degree ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No If Yes, What Level: _____

Degree Pursuing: _____

Current or Previous Military Service: ☐ Yes ☐ No If Yes, What Service: _____

Years of Service: _____ Highest Rank: _____ Combat Experience: ☐ Yes ☐ No

RELATIONAL INFORMATION

Current Marital Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Relationship Status: ☐ Yes ☐ No

If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Spouse: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

With Whom Do You Currently Live (*Check all that apply)*: ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s)
☐ Sibling(s) ☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

PARTNER INFORMATION

Full Name: □ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____
How Long Have You Known Your Partner: _____ Age: ____ Preferred Name: _____
Race: □ White □ Black □ Latino □ Asian □ Other: _____ Sex: □ Male □ Female
Occupation: _____ Average Hours Worked Per Week: _____
Last Year of High School Completed: □ 9 □ 10 □ 11 □ 12 □ GED □ AA College: □ 1 □ 2 □ 3 □ 4
□ Master's Degree □ Doctorate Degree □ Other: _____ Currently in School: □ Yes □ No
Describe this Person: _____

CHILDREN

List Your Children, Living or Deceased. Include Children You Have Placed for Adoption, Aborted, Miscarried, or Still Birthed (*Use back if necessary)*

1. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Natural □ Step □ Adopted Occupation: _____
   Living with You: □ Yes □ No Describe Him/Her: _____
2. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Natural □ Step □ Adopted Occupation: _____
   Living with You: □ Yes □ No Describe Him/Her: _____
3. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Natural □ Step □ Adopted Occupation: _____
   Living with You: □ Yes □ No Describe Him/Her: _____
4. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Natural □ Step □ Adopted Occupation: _____
   Living with You: □ Yes □ No Describe Him/Her: _____

FAMILY OF ORIGIN

List Members of Your Immediate Nuclear Family or Origin *(Use back of necessary)*

1. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Relationship with Him/Her: _____
2. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Relationship with Him/Her: _____
3. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Relationship with Him/Her: _____
4. Name: _____ Current Age or Year of Death: _____ Sex: □ Male □ Female
   Relationship to You: □ Mother □ Father □ Sibling □ Step □ Other: _____
   Occupation: _____ Describe Him/Her: _____
   Describe Nature of Relationship with Him/Her: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone: _____
Address: _____ City: _____ Zip Code: _____
Are You Currently Receiving Treatment: □ Yes □ No If Yes, Please Specify: _____
List any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas, or Related Treatments You've Had *(Use back if necessary)*: _____
Have You Ever Had a Miscarraige: □ Yes □ No □ N/A
Abortion: □ Yes □ No □ N/A If Yes, □ Medical □ Non-Medical When: _____ Age: _____
Rate Your Physical Health: □ Very Good □ Good □ Average □ Declining □ Poor □ Very Poor
What Positive Things do You do to Impact Your Physical Health: _____

MEDICATION INFORMATION

List All Current Medications You are Taking, Including Those You Seldom Use or Take Only as Needed

1. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
2. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
3. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____
4. Medication: _____ Dosage: _____
   Improves/Prevents/Controls: _____ Treating: _____

SUBSTANCE USE

Do You Drink Alcohol or Use Drugs: □ Alcohol □ Drugs □ Both □ I Do Not Drink Alcohol or Use Drugs
Do You Smoke Tobacco: □ Yes □ No
If You use Alcohol or Drugs, What Kind do You use *(Check all that apply)*:
□ Beer □ Wine □ Liquor □ Marijuana/Pot/Hash/etc □ Cocaine/Crack/etc □ Sedatives/Valium/etc
□ Amphetamines/Speed/Meth/etc □ Opiods/Herion/Opium/etc □ Hallucinogens/Acid/Ecstasy/etc
□ Inhalant/HuffingWhipits/etc □ Phencyclidine/Mushrooms/etc □ Over the Counter/Prescription Meds
If You use Alcohol or Drugs, How Often do You use Them: □ Every Day □ Several Times per Week
□ Several Times per Month □ Once or Twice per Month □ Several Times per Year □ Once per Year
Have You Ever Felt Like You Should Cut Down on Your Alcohol or Other Drug Use: □ Yes □ No
If Yes, Explain: _____
Has a Friend or Relative Discussed Concerns About Your Use: □ Yes □ No
If Yes, Explain: _____
Have You Ever Felt Guilty About Your Drinking or Drug Use: □ Yes □ No
If Yes, Explain: _____
Have You Ever Had to Take a Drink or Use a Drug the Next Day to Steady Your Nerves: □ Yes □ No
If Yes, Explain: _____
Is There a History if Problems with Alcohol or Drug Use in Your Family: □ Yes □ No
If Yes, Explain: _____
Are You in Recovery from any Addictive Behavior: □ Yes □ No Explain: _____
Do You Engage in any of the Following Behaviors in such a way that it May be an Issue or Concern:
□ Gambling □ Spending □ Sexuality □ Eating □ The Internet □ Exercise □ Other: _____

ABUSE HISTORY

Have You Ever Been Physically, Sexually, Emotionally, or Mentally Abused: □ Yes □ No

If Yes, Explain: _____

LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT

Do You Have Past/Current Legal Involvement: □ Yes □ No

If Yes, Explain: _____

Have You Ever Been Involved with the Department of Children and Families (DCF) or a Similar Agency in Another State: □ Yes □ No

If Yes, Explain: _____

Have You Ever Been Involved in any Kind of Domestic Violence: □ Yes □ No

If Yes, Explain: _____

CURRENT STATUS

Check All of the Following Problems that Apply to You and/or Your Family:

Stress ----------□ You □ Family
Panic----------□ You □ Family
Anxiety----------□ You □ Family
Nervousness--------□ You □ Family
Shyness ----------□ You □ Family

Physical Abuse ----□ You □ Family
Sexual Abuse ------□ You □ Family
Emotional Abuse--□ You □ Family
Verbal Abuse ------□ You □ Family

Trauma----------□ You □ Family
Sexual Trauma ----□ You □ Family
Head Trauma ------□ You □ Family

Anger----------□ You □ Family
Temper----------□ You □ Family
Aggressiveness----□ You □ Family
Loss of Control----□ You □ Family
Impulsiveness------□ You □ Family
Compulsivity ------□ You □ Family

Apathy ----------□ You □ Family
Unhappiness -------□ You □ Family
Loneliness----------□ You □ Family
Hopelessness-------□ You □ Family
Defective Feelings□ You □ Family
Unwanted Thoughts □ You □ Family
Inferiority Feelings□ You □ Family
Depression ---------□ You □ Family
Self Injury----------□ You □ Family
Suicidal Ideation --□ You □ Family
Suicide Attempt---□ You □ Family
Homicidal Ideation□ You □ Family
Ambition----------□ You □ Family

Concentration------□ You □ Family
Racing Thoughts --□ You □ Family
Making Decisions-□ You □ Family
Guilt ----------□ You □ Family

Grief----------□ You □ Family
Recent Death-------□ You □ Family
Terminal Illness---□ You □ Family

Marriage ----------□ You □ Family
Pregnancy ----------□ You □ Family
Children----------□ You □ Family
Being a Parent-----□ You □ Family
Infidelity ---------- □ You □ Family

Communication ---□ You □ Family
Friends ----------□ You □ Family

Legal Matters------□ You □ Family
Finances ----------□ You □ Family
Trouble with Job --□ You □ Family
Career Choices ----□ You □ Family

Sexual Problems --□ You □ Family
Pornography -------□ You □ Family

Alcohol Use--------□ You □ Family
Drug Use ----------□ You □ Family
Nicotine Use-------□ You □ Family

Bad Dreams --------□ You □ Family
Memory----------□ You □ Family
Eating Problems---□ You □ Family

LEVEL OF DISTRESS

On a Scale from 1 to 10, Indicate Your Level of Distress *(1=Very Little Distress; 10=Extreme Distress)*

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Are You Currently Experiencing Any Suicidal Thoughts: □ Yes □ No

Have You Experienced Suicidal Thoughts in the Past: □ Yes □ No

Have You Ever Attempted Suicide: □ Yes □ No

If Yes, When and How: _____

Have Any of Your Friends or Family Members Ever Completed or Attempted Suicide: □ Yes □ No

If Yes, When and Who: _____

PRESENTING CONCERN AND GOALS

Describe Your Reason for Coming to Counseling: _____

What Have You Done About it up to this Point: _____

What is Your Desired Result of Counseling: _____

How Long do You Believe Counseling Should Last: _____

What Information Should be Known at the Outset of Counseling: _____

PERSONALITY INFORMATION

Mark All Words Which You Feel Best Describe You:

□ Active □ Ambitious □ Self-Confident □ Persistent □ Nervous □ Hardworking □ Dedicated
□ Impatient □ Impulsive □ Moody □ Excitable □ Imaginative □ Calm □ Serious □ Easygoing
□ Shy □ Good-Natured □ Introvert □ Extrovert □ Depressed □ Likeable □ Leader □ Quiet
□ Submissive □ Self-Conscious □ Insecure □ Lonely □ Sensitive □ Passive □ Indifferent

Pick 3-5 Other Words to Describe Yourself: _____

Pick 5-7 Words Others Would Use to Describe You: _____

PREVIOUS COUNSELING

Have You Ever had a Severe Emotional Upset? □ Yes □ No Explain: _____

List any Previous Counseling, Treatment, or Residential/In-Patient Care You Have Received:

1. Therapist: _____ Location: _____
   Dates Attended: _____ Reason: _____
2. Therapist: _____ Location: _____
   Dates Attended: _____ Reason: _____

What was the Outcome of any Prior Counseling: _____

EMOTIONAL HEALTH

How Many Supportive People (Who You Can Depend On) do You Currently Have in Your Life:

□ None (0) □ Some (1-5) □ Average (6-10) □ Many (10+)

Have You Ever Attended a Support Group Addressing the Topic(s) for Which You are Seeking Counseling: □ Yes □ No Explain: _____

Have You Ever Been Hospitalized for Emotional/Psychological Concerns: □ Yes □ No

If Yes, Explain: _____

What Positive Things do You do to Impact Your Emotional Health: _____

RELIGIOUS BACKGROUND/SPIRITUALITY

Do You Subscribe to a Religion/Form of Spirituality: □ Yes □ No Explain: _____

Do You Believe in a Higher Power: □ Yes □ No □ Uncertain

Is Your Religion/Spirituality a Source of Strength: □ Yes □ No □ Uncertain

Briefly Describe the Religious/Spiritual Environment of Your Home as You Were Growing Up:

_____

Do You Regularly Attend a Place of Worship: □ Yes □ No If Yes, Where: _____

Do You Have a Spiritual Support System: □ Yes □ No If Yes, Who: _____

Would You Like Your Counselor to Address how Your Religion/Spirituality Might Assist You in the Counseling Process: □ Yes □ No □ Uncertain

This concludes the psychosocial portion of your intake process. Thank you for taking the time to complete this inventory. The information that you have supplied will help to provide you with the best service possible.