CLIENT INTAKE PACKET

A thorough assessment is important because it can provide your counselor with helpful information about your background. In an effort to ensure that our counselors can spend time in-session focusing on what is most important to you instead of collecting this information, I ask that you complete this packet and bring it with you to your first appointment.

Name:_____

Address: _____

Home Phone:_____

Cell Phone: _____

Email Address: _____

May I...

Leave messages at the above phone numbers? ☐YES ☐NO

Send appointment reminders via text message to the above cell number? ☐YES ☐NO

Today's Date: _____

DOB: _____

Should I…

Send appointment reminders to the above email address? Y or N Contact you via email if I cannot reach you by phone? Y or N

Emergency Contact Person, name and phone number:

_____

How did you hear about Embrace Your Serenity Counseling?

_____

Briefly describe the issues/problems that led you to counseling today:

_____

_____

_____

What are some goals you would like to accomplish during your time in counseling?

_____

How will you know when your goals have been met? In other words, what would you like to see improve/ notice about yourself, and or situation?_____

_____

CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues."

☐ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
☐ Aggression, violence
☐ Alcohol use
☐ Anger, hostility, arguing, irritability
☐ Anxiety, nervousness
☐ Attention, concentration, distractibility
☐ Career concerns, goals, and choices
☐ Childhood issues (your own childhood)
☐ Codependence
☐ Confusion
☐ Compulsions
☐ Decision making, indecision, mixed feelings, putting off decisions

- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, under-eating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness, Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Housework/chores—quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, significant other, relatives, or at work)
- ☐ School problems (see also "Career concerns")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, Insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness

☐ Suicidal thoughts
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization and confusion
☐ Threats, violence
☐ Weight and diet issues
☐ Withdrawal, isolating
☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
Any other concerns or issues:

Treatment History

Have you ever participated in counseling, psychotherapy, psychiatric/mental health treatment, or substance abuse treatment?

PSYCHOSOCIAL HISTORY

Trauma History

Did you experience any physical, sexual, or emotional/psychological abuse or neglect during childhood or as an adult? If so, please describe:

Have you had any experiences you'd consider to be traumatic (e.g., threat of serious harm/injury, natural disaster, victim of a crime, traumatic losses/deaths, etc.)? If so, please describe:

Family Psychiatric History

Has anyone in your family ever been diagnosed or treated for a mental health disorder or for an alcohol- or drug-related problem? Has anyone had these problems but not been treated? If either applies, please indicate below:

Family Member Problem/Disorder Describe Treatment (if any):

Medical Conditions & History

Do you have any current or recent medical/physical concerns? ☐No ☐Yes; Describe:

Do you have a primary care physician? ☐No ☐ Yes
Name of Physician/Practice:

Do you have health insurance? ☐ Yes ☐ No
Please describe any history of surgeries, significant medical procedures, or ER visits, or major illnesses (Including dates if possible):

Medications (including dosages, prescribing physician, and purpose of medication):

Allergies:

Substance Use

Please enter the following information for any substances including alcohol, tobacco, and drugs that you currently use or have used in the past:

Substance Past Use? (Yes/No) Current Use? (Yes/No)

How often/how much in past year?

Family History

Were you adopted? ☐Yes ☐ No

Who lived with you growing up?

Did you have brothers or sisters? ☐Yes ☐No

If so, list their names and ages:

Did/do you have stepparents? ☐Yes ☐ No
How would you describe your family growing up?

What was your parents' relationship with each other like?

What was your relationship with your mother like growing up?

What is your relationship with her like now (if living)?

What was your relationship with your father like growing up?

What is your relationship with him like now (if living)?

Did you experience any physical, emotional, or sexual abuse or neglect as a child or as an adult? ☐No ☐Yes Describe:

What is your relationship status (check all that apply)? ☐ Single
☐ Co-habituating ☐ divorced ☐ Separated ☐ Other:
Do you have children? ☐No ☐Yes Names and ages:

Social, Spiritual, & Developmental History

Where were you born?

Where did you live growing up?

Were there any complications with your birth?

Were there any developmental delays growing up?

What were your friendships like growing up?

Describe your friendships now:

Who do you turn to for support?

How many serious relationships have you been in your life?

Describe your history of romantic relationships:
Are you in a relationship now? ☐Yes ☐No If so, for how long?

☐ Married ☐ Dating

Describe your relationship with your significant other:

Describe your sexual orientation: ☐Heterosexual ☐Gay ☐ Lesbian ☐Bisexual

☐ Transgender ☐Pansexual ☐Questioning ☐ Non-binary Other:

What are your preferred pronouns? She/Her, He/Him, They/Them/ Their, Ze/Hir/, Ze/Zim, Zirs

Describe your religious or spiritual beliefs:

Describe any social groups or institutions you are involved in (e.g., clubs, associations, congregations):

What do you like to do during your free time?

Educational and Vocational History

What was school like for you growing up?

What is the highest level of education/highest grade you completed?
If you went to college or grade school, what degrees or certifications did you earn?

Describe your employment history:

Are you working now? ☐Yes ☐No
What is your occupation? Annual income?
Describe any vocational/occupational goals you may have for the future:

Legal History

Have you ever been arrested? If so, when and what charge(s)?

Describe any current legal concerns:

Other Information

What do you excel at? (This could be anything. There isn't a right or wrong answer)

Anything else you want me to know? ☐ Yes ☐ No