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Confidential Intake Form **Date: _____**

Name of Client: _____ **Birthdate: _____**

Preferred Name or Pronoun: _____

Guardian(s) Name(s): _____

Address: _____ **Apt#: _____**

City: _____ **State: _____** **Zip: _____**

Cell #: _____ May I leave a message?: Yes No May I text?: Yes No

Home #: _____ May I leave a message?: Yes No

Work #: _____ May I leave a message?: Yes No

Email Address: _____ May I contact you via email? Yes No

Note: Confidential information will not be shared via email. This is only used for setting and confirming appointments.

How did you hear about us? _____

Who shall we contact in case of emergency?

Name: _____ Phone (___)_____

Reason for seeking help at this time?

_____

_____

Please list client's strengths as you see them.

_____

_____

Please list things client does that make client feel good.

_____

_____

Please check all client behaviors and symptoms you consider problematic:

❑ Distractibility ❑ Hyperactivity ❑ Impulsivity ❑ Sadness/depression ❑ Hopelessness ❑ Self-harm behaviors ❑ Low self-worth ❑ Change in appetite ❑ Anxiety/worry ❑ Isolation ❑ Thoughts of hurting others	❑ Compulsive behavior ❑ Social discomfort ❑ Aggression ❑ Sleep problems ❑ Toileting problems ❑ Lack of motivation ❑ Obsessive thoughts ❑ Boredom ❑ Peer/sibling conflict ❑ Irritability/anger\ ❑	❑ Lying ❑ Nightmares ❑ School/academic problems ❑ Sexual behavior ❑ Fear away from home ❑ Crying spells ❑ Wide mood swings ❑ Poor memory ❑ Fatigue ❑ Other_____ _____ _____

How are behaviors and symptoms affecting client?

_____

_____

How are behaviors and symptoms affecting relationships with others/family/peers?

_____

_____

When did symptoms begin and how have these concerns evolved over time?

_____

_____

_____

Please list all impactful family of client including all living with the client:

Name_____ Relationship_____ Age_____

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Name_____ Relationship_____ Age_____

Family History impacting the client: (neglect, trauma, abuse, divorce, adoption, etc.)

_____

_____

_____

_____

_____

Family History of Illness (mental health, developmental delays or otherwise):

_____

_____

_____

Please list all current drugs, medications and dosages:

Name of Substance	Dosage	Name of Prescribing Doctor	When did you start taking it?

Previous history of counseling? No Yes If yes, when? _____

Who or Where?_____ May I contact them? No Yes

If yes, please provide a phone # or Email: _____

Please list any other resources or people who have or could help you

_____

_____

Are you currently working outside the home? _____

Employer:_____

Position: _____ For how long? _____

Education:_____

Military History:

_____

_____

_____

Have you or any family member ever attempted suicide? No Yes- If Yes please explain:

_____

_____

Are there any current legal matters at this time? No Yes- If Yes please explain:

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

_____

Sign and Date: _____