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PERSONAL INFORMATION SHEET

CLIENT INFORMATION

Name (First, Middle(s), Last) _____ Date _____

Preferred Name _____ Date of birth _____ Age _____

OPTIONAL: Sex/Gender _____ Race/Ethnicity _____

Address _____

City/State/Zip _____

Telephone: Daytime _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Evening _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Cell/Pager _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Email _____ Detailed msgs okay? ..... ☐ Yes ☐ No

Last 4 digits of Social Security Number _____ Referred by _____

Two Emergency Contacts, preferably one in same household as you and one not.

Name	Relationship	Phone#	Location (City, State)
Name	Relationship	Phone#	Location (City, State)

HEALTH INSURANCE INFORMATION

The named client is eligible for two or more insurance policies. ..... ☐ Yes ☐ No

Guarantor's Name _____ Date of Birth _____

Employer _____ SSN (last 4 dig): _____

Employer Address/Phone _____

Primary Insurance _____ Policy # _____

Address _____ Group # _____

Secondary Insurance _____ Policy # _____

Address _____ Group # _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER(S) LISTED ABOVE. I AGREE TO MAKE ANY CO-INSURANCE PAYMENTS REQUIRED BY MY POLICY AT THE TIME OF SERVICES. I UNDERSTAND THAT I WILL BE BILLED FOR SESSIONS THAT ARE NOT CANCELLED WITHIN 24 HOURS. I ALSO UNDERSTAND THAT A $25 FEE WILL BE ADDED TO ACCOUNTS REFERRED TO A COLLECTIONS AGENCY DUE TO NON-PAYMENT.

_____ _____

Signature of responsible party **Date**

Name of Client _____

STANDARD INTAKE

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PRESENTING CONCERNS

1. What is the main reason you seek counseling at this time? _____

_____

_____

Check any symptoms associated with these problems that concern you:

- ☐ Anxiety / Frustration
- ☐ Boredom/Disinterest
- ☐ Emotional Numbness
- ☐ Feelings of Fear or Dread
- ☐ Guilt or Shame
- ☐ Irritability
- ☐ Low Energy
- ☐ Physical complaints (please specify)
- ☐ Sadness
- ☐ Social Withdrawal
- ☐ Overeating / ☐ Under eating
- ☐ Weight Gain / ☐ Weight Loss
- ☐ Body Image Issues
- ☐ Racing Thoughts
- ☐ Suicidal Thoughts
- ☐ Trauma History
- ☐ Anger
- ☐ Behavior Changes
- ☐ Confusion
- ☐ Dissociation
- ☐ Grandiosity
- ☐ Hallucinations
- ☐ Increase in Substance Use
- ☐ Obsession
- ☐ Paranoia
- ☐ Rage
- ☐ Violent Behavior
- ☐ Educational Problems
- ☐ Employment Problems
- ☐ Financial Problems
- ☐ Housing Problems
- ☐ Legal Problems
- ☐ Social Problems

Details: _____

_____

2. Describe your (check one):

Current attitude toward life	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Best attitude this past year	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Hopefulness for things getting better	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Ability to think clearly	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Ability to feel many emotions	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Quality of friendships	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Belief counseling will help	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*

3.

Overall physical condition	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Diet/nutrition	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Exercise/ activity level	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
How you feel about your body	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Work efficiency	☐ *Excellent*	☐ *Good*	☐ *Fair*	☐ *Poor*
Sleep (check all that apply)	☐ *Regular*	☐ *Adequate*	☐ *Peaceful*	
	☐ *Irregular*	☐ *Inadequate*	☐ *Disrupted*	

4. When did these problems start? _____

_____

_____

5. Have you previously sought help for these symptoms or problems? If so, what has been helpful? _____

_____

_____

6. Please describe your:
   …central focus/ concern(s). _____
   _____
   _____
   …belief(s) about the cause of the current problems. _____
   _____
   _____
   …expectations/ goals for therapy. _____
   _____
   _____

7. What concerns, beliefs, or observations have others expressed regarding your current problems? What do they think should happen?: _____
   _____
   _____

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TREATMENT HISTORY

8. Have you ever seen another mental health professional? *(counselor, psychiatrist, marriage counseling)*..... ☐ Yes ☐ No
   Who/ when/ how long/ reason: _____
   _____
9. Have you ever been hospitalized for mental/ emotional/ psychiatric problems or substance abuse?..... ☐ Yes ☐ No
10. Name of primary doctor: _____
    Location/Phone#: _____
    _____
11. Any current or past medical issues?..... ☐ Yes ☐ No
    Details: _____
    _____

HOUSEHOLDS/RELATIONSHIPS

12. Current relationship status and since when? *(e.g. single, dating, partnered, cohabitating, married, separated, divorced/broken-up, etc.)*: _____
    _____
13. Describe your current household and any recent changes (*names, ages, and relationship to you, and for how long*): _____
    _____
    _____
14. Atmosphere of your current and/or recent household(s) (*e.g. loving, supportive, chaotic, abusive, lonely, tense, volatile*): _____
    _____
15. Significant current or past adult relationships *(dates and duration)*: _____
    _____
16. If you have children, please list them by name and age: _____
    _____
17. If you have pets, please list them and describe: _____
    _____

Name of Client _____

FAMILY OF ORIGIN (CHILDHOOD / GROWING UP)

18. Your cultural or ethnic background growing up *(region of the country/ world; urban vs. rural; language(s) in home; ethnicity/ race; immigrant or refugee family history):*

    _____

    _____

19. Your original family and what it was like for you *(include caretakers, other adults, siblings, and other children living in your childhood household(s))*. _____

    _____

    _____

20. Family members, loved ones, or friends who have been generally or currently supportive: _____

    _____

21. Family members, loved ones, or friends who have been generally or currently unsupportive or with whom you have had frequent conflict:

    _____

    _____

22. Significant events or circumstances:

    Significant childhood events/ circumstances *(indicate your age):*_____

    _____

    _____

    Significant recent events/ circumstances:_____

    _____

    _____

    Other significant lifetime events/ circumstances: _____

    _____

    _____

BACKGROUND INFORMATION

23. Are you currently employed? ..... ☐ Yes ☐ No

    Occupation, Employer, how long: _____

    _____

24. Have you:

    … ever been abused or assaulted? ..... ☐ Yes ☐ No
    … ever been abusive or assaultive to others? ..... ☐ Yes ☐ No
    … ever attempted suicide? ..... ☐ Yes ☐ No
    … had any thoughts of harming self or others? ..... ☐ Yes ☐ No

    Details: _____

    _____

25. Do you take any prescription or other medications?
    (include any vitamin or herbal supplements or teas) ..... ☐ Yes ☐ No

    Name/ dosage/ frequency/ reason: _____

    _____

    _____

26. Do you take non-prescription/recreational drugs? ..... ☐ Yes ☐ No
27. Do you drink alcoholic beverages? ..... ☐ Yes ☐ No

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Name of Client _____

OTHER INFORMATION

28. Your hobbies or leisure activities: _____
_____
29. Your strengths: _____
_____
30. Your weaknesses: _____
_____
31. Is religion/spirituality important to you? ..... ☐ Yes ☐ No
Religious/spiritual "preference": _____
Your satisfaction: ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*
32. Are you currently in school? ..... ☐ Yes ☐ No
Highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12
College: 1 2 3 4 5 6 Year and Major: _____
Name/Location of College: _____
33. Any arrests or charges? ..... ☐ Yes ☐ No
Date(s) and charge(s): _____ Upcoming Court Date(s): _____
34. Describe your family/genetic history ***(indicate who, and type of problem)***:
Physical illnesses: _____
_____
_____
Mental or emotional illnesses: _____
_____
_____
Alcohol or drug use problems? _____
_____
_____

NOTES

Please use the space below or the other side for any other information I should know.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Client Signature _____ Date _____

Counselor Signature _____ Date _____

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