

Susan Wilner, LMHC

Client Intake Form

The following information is requested so that I may provide you with the most expedient and effective psychotherapy possible. I appreciate your efforts in answering the questions thoroughly and honestly to the best of your ability.

Please bring completed form with you to your next appointment.

Date of Intake: ___/___/___ Date of Birth: ___/___/___ Age: _____

First Name: _____ Last Name: _____

Street address: _____

City _____ State: _____ Zip Code: _____

Home Phone _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Is it acceptable to contact you/leave you a message on your phone? _____

Best time way to reach you last minute _____

How were you referred to my practice? Person: _____ Address: _____ Name of Website: _____

Relationship status: (please circle) Single Married Separated/Divorced Widowed Partnered/S.O.

Please provide the name and phone numbers of 2 emergency contacts:

Name: _____ Relation: _____ phone: _____

Name: _____ Relation: _____ phone: _____

If client is an adolescent, please complete the following questions:

1 Name of Parents (Guardians) _____ Phone: _____

2 Name of Noncustodial/Other Parent _____ Phone: _____

3 Name of Siblings _____ Others in the House? _____

4 Teen's relationship with Other Parent/Guardian: _____

5 Is the Other Parent/Guardian aware of and supportive of counseling? _____

6 Teen's School and Grade Level _____

7 Teen's School Performance/Behavior: _____

Medical Information:

Primary Care Physician: _____

Address: _____ Phone: _____

Permission to contact (please circle)? Yes No

Allergies: _____

Are you currently being treated for a physical condition and/or a communication disorder (e.g. hearing impairment, stuttering)? (please circle) Yes No

If yes, please describe and name professionals treating you. _____

Are you currently taking prescribed physiological medications? (please circle): Yes No

If yes, please list each medication and its purpose below:

Mental Health Information:

Your Current Prescriber: (please circle) Psychiatrist Nurse Practitioner PCP Other

Name _____ Address _____ Phone _____

Permission to contact (please circle)? Yes No

List any mental health/psychiatric medications *previously taken and currently taken*.

When	From Whom	Name of Medication	For What	With What Results
------	-----------	--------------------	----------	-------------------

- 1
- 2
- 3
- 4
- 5

Please circle any of the following issues that pertain to you now or in the past:

Abuse/Neglect	Health Problems	Relationship Difficulties
Acting Out Behaviors	Hyperactivity	School Problems/Poor Grades
Alcohol/Drug Use	Insomnia/Sleep Difficulties	Self Control
Anger/Temper Issues		
Anxiety or Fears	Irritability	Sexual Problems or Sexuality Issues
Career Difficulties	Legal Issues	Shyness
Concentration Problems	Loneliness	Social Skills Deficits
Depression	Low Self-esteem	Stress
Divorce/Separation	Nightmares	Suicidal Thoughts or Actions
Domestic Violence	Memory	Tiredness
Eating Problems/Disorders	Odd behaviors	Thoughts of Hurting Others
Family Conflicts/Dysfunction	Panic	Trauma History
Financial Difficulties	Parenting Difficulties	Truancy
Gang Involvement	Psychosis	Cutting/Self-mutilation
Stuttering	Difficulty Hearing	Learning Disabilities

Have you ever been in psychological, psychiatric or counseling services before? (please circle) Yes No
If yes, please indicate:

When	With Whom	For What?
_____	_____	_____
_____	_____	_____

Have you ever attempted suicide: Yes No

If yes, how and when: _____

Are you currently experiencing suicidal thoughts?: Yes No

Homicidal Thoughts?: Yes No

Have you ever been admitted to a hospital for psychiatric reasons? Yes No

If yes, provide details : _____

Please briefly explain below the reason that you have now decided to seek counseling services:

Personal History:

Family of Origin:

Relative	Name	Current Age	Occupation
----------	------	-------------	------------

Father _____

Mother _____

Stepparents _____

Grandparents _____

Brothers _____

Sisters _____

Others _____

Relationships in Your Family of Origin:

Please describe the following: Your parents' relationship with each other:

Your parents' health problems, use of substances (alcohol, drugs), and mental or emotional difficulties:

Your relationship with your brothers and sisters, in the past and present:

Marital/Relationship History:

Spouse(s)/Partner(s) Name(s)	Age(s)	Length of Relationship(s) (months/years)
------------------------------	--------	--

Children: (Indicate with a "P" those from a previous marriage or relationship.)

Name(s)	Current Age(s)	Sex	P?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Present Relationships:

How do you get along with your present spouse/partner/boyfriend/girlfriend?

How do you get along with your children?

How many close friends do you have? _____

Abuse History: Please circle: "I was *not* abused in any way." "I was abused."
If you have experienced abuse, please indicate *how long, by whom and the type(s) of abuse.*

<u>Use of Alcohol and Street Drugs:</u>	(Please circle.)	
Have you ever felt the need to cut down on your drinking?	Yes	No
Have you ever felt annoyed by someone's criticism of your drinking?	Yes	No
Have you ever felt guilty about your drinking?	Yes	No
Have you ever taken an "eye-opener"?	Yes	No
How much alcohol do you consume each week on average? _____		
How many cigarettes do you smoke a week? _____		
Do you use street drugs? Yes No If yes, which ones and how often?		

Legal History:

Please describe in detail any legal matters you have been involved with in the last 10 years including arrests, convictions, or suits.

Have you been a victim of a crime? Yes No
If yes, please explain the circumstances.

Do you have a Restraining Order in effect against any person(s) at this time? Yes No
Does anyone have a Restraining Order in effect against you at this time? Yes No
If yes to either, please explain.

Have you used Victim Compensation Funds to cover any of your mental health counseling services in the past? Yes No

Are you planning to do so to cover counseling costs with Susan Wilner, LMHC? Yes No

Education and Training:

Dates	Schools	Did you graduate?
_____	_____	_____
_____	_____	_____

Client/Guardian Signature: _____ **Date:** _____