2770 Main St. Suite 132 Frisco, TX 75033
havencounseling.com

(Required for ALL Clients)

CLIENT INTAKE FORM

Date: ____________________

Name: ____

Address: ____

____

Email address: ____

Phone: Home _____________ Work ____________ Cell ______________

May we contact you at your: Home: ___ yes ___ no - Work: ___ yes ___ no

Sex: M___ F ___ Date of birth: _______________ Age: _________

Social Security # _____________________ DL # ____________________

Marital status: ________________ If married, how long? _____________

Spouse name: __________________________________

Your employer: ____________________________ How long: __________

Job title/position: ____

Religion as a child: ______________________

Currently: ______________

People currently in household including yourself:

Name Relationship Age Sex Education Level

1. Self ____

2. ____

3. ____

4. ____

Children living out of the home _____________________________

Ages ________________________________

In your own words describe why you are seeking counseling:
____
____
____

With whom have you previously consulted about the problem(s)?

(Names & Dates) ____
____
____

Are you currently seeing another mental health professional? Yes/No

(Names & Dates) ____
____

____

Referred by: __________________________

List any medication(s) you are currently taking
____

____

IN CASE OF EMEGENCY

Name of Local Friend or Relative (not living at same address)

____

Relationship to Client

____

Mobile Phone Nr:

____

MEDICAL HISTORY

Name of Primary Care Physician:
____

Physician's Address:____

Physician's Phone: _________________________________

Date of last medical evaluation:________________________

Date of next appointment:___________________________________

Current medications being taken:
1)_________________________ Dosage/Freq____________ Start Date____________Purpose__________________________________
2)_________________________ Dosage/Freq ____________ Start Date____________Purpose__________________________________
3)_________________________ Dosage/Freq ____________ Start Date____________Purpose__________________________________
4)_________________________ Dosage/Freq ____________ Start Date____________Purpose__________________________________ Prescribed by:
____
____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital

____

____

____

Do you use recreational drugs? (Circle One) YES NO
If yes, when did you stop? ___________________________________

Mo/Yr Reason

____ ___________

____

____

YES NO If no, have you used previously? (Circle One)YES NO

Type of Drug

____

____

____

Do you smoke cigarettes? (Circle One) YES NO

Do you drink alcohol? (Circle One) YES NO
If yes, please list:
Type of Alcohol

____

____

How much? How often?

____

____

____

If no, did you drink previously? (Circle one) YES NO

How much? How often?

____

____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

____
____
____

Describe any important medical history, chronic ailments, or other health problems you experience: _______________________________________

____
____
____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:____

____
____

What was the last year of school you completed? ____________

If you did not complete high school, please explain:

____
____ Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)____
(2) School(s)____
(3) School(s)____
How would you describe your current support network? (friends, relatives, etc.):

____
____
____

Please check all information which applies to your biological parents:

MOTHER ____ living ____ deceased

____ married
____ divorced
____ remarried ____# of times

FATHER

_____ living
_____ deceased
_____ married
_____ divorced
_____ remarried _____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your “real” parents? If so, whom?

____
____

Where do your parents live?

Mother ____

Father ____

Describe your relationship with your mother while growing up:

____
____

Currently:

____
____

Describe your relationship with your father while growing up:

____
____

Currently:

____
____

List first names and ages of brothers & sisters:

____
____
____
____

Describe any family problems which occurred while growing up relating to:
Alcohol/drug abuse:

____
____

____
____
____

Sexual/physical/emotional abuse:

____
____
____
____
____

MENTAL STATUS

Check all that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry
____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable
____confused _____extreme ups/downs _____jealous _____hopeless ____helpless.

Describe any other feelings you have had:

____
____
____

What activities or hobbies do you participate in?

____
____
____

Do you participate in regular exercise? (Circle One) YES NO

Describe: ____

Describe your current working environment:

____
____
____

Have you had any change in sleeping habits? (Circle One) YES NO
Describe:____
____
____

Have you had any change in eating habits? (Circle One) YES NO Describe:
____
____
____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:
____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:
____

Have you **attempted suicide recently** or in the **past**? (Circle One)

YES NO

If so, please give a brief description with dates:
____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO
If yes, please explain:
____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:
____
____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):

____
____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior.

Please explain: ____
____
____
____
____

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form? You may also use this space to complete earlier responses.

____
____
____
____
____
____
____
____

Please list your therapy goals:

____
____
____
____
____
____
____
____
____

THANK YOU! Please return this confidential intake form to your therapist.