Joy Counseling and Consulting, LLC

CLIENT INFORMATION INTAKE FORM

THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL

(PLEASE PRINT CLEARLY)

Today's Date: _____

Name: _____Birthdate_____Age_____Gender _____

Address_____

City_____ State_____ Zip_____

Cell / Home Phone (___) _____Work Phone ( ) _____

Can we leave a message? Yes /No Text ? Yes/No Best Place to Leave a Message ( ) _____

Who were you referred by/how did you hear about us? _____

Level of Education: HS___College____Other___ Place/Type of Employment_____

How long? _____ If unemployed, how long: _____ what type of work did you do? _____

Marital Status (Parents if for a child) Married_____# of years____; Divorced___# of years _____;

Separated _____ # of years _____; Widowed____# of years____; Single____; Living with_____

Spouse's/Partner Name_____Spouse's/Partner's Occupation_____

CHILDREN (SIBLINGS IF FOR A TEEN)

NAME	BIRTHDATE	GENDER

In Case of Emergency Notify: _____ Phone:_____ Relationship:_____

Have you ever been hospitalized for psychiatric reasons? Y N If yes, what were the circumstances? Please include dates: _____

When was your last full physical exam? _____

Any physical/medical issues? _____

Sleeping issues? Y N How many hours of sleep do you get each night? _____

List any medications you are presently taking and dosage: _____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc) or mental health AND/OR substance abuse issues?_____

_____

How much do you drink on average? _____

What drugs have you tried/use?_____ Last use? How often? How much?

Do you have current thoughts of suicide? Y / N

If yes, do you have a plan? Y / N explain_____

Do you have the means to carry out the plan? Y/N

Have you *ever* had thoughts about suicide? Yes No Homicide? Yes No

Have you ever attempted suicide? Yes No If yes, how many times? _____

What do you have to live for? 1) _____ 2) _____ 3) _____

Do you engage in any self-injurious behaviors (cutting, burning, etc.)? Y / N if yes, explain

_____

Have you ever had concern about eating habits? Y / N If yes, explain_____

Do you have any sexual concerns? Y / N If yes, explain _____

How often do you exercise? _____ What type? _____

What do you do for self-care? _____

How do you spend time relaxing/having fun? _____

Reason(s) for seeking counseling at this time? What seems to be the problem as you see it?

_____

_____

Have you ever been in counseling before? Y N For how long? _____

Was it helpful? Y N Please explain: _____

Is this your choice for counseling? (if no, please explain) _____

_____

Please check any of the following that are concerns for you or that you have experienced in the past 6 month?

___Hallucinations	___ Delusions	___Paranoia	___Mania/hypomania
___Headaches	___Nervousness	___Dizziness	___ Bowel Troubles
___ Low self esteem	___ Worthlessness	___ Hopelessness	___ Helplessness
___Shyness	___Stomach Trouble	___ Social anxiety	___ Isolating
___Anxiety	___ Fears/phobias	___Fatigue	___Legal Matters
___Impulsivity	___Anger / temper	___Risky behavior	___ Memory problems
___Decision making	___ low motivation	___ Poor sleep	___Nightmares
___Abandoned	___ Rejection	___ low/high Energy	___ Superiority
___Inferiority	___Drug/Alcohol Use	___Loneliness	___Marriage conflict
___Sexual Problems	___Work problems	___Under/Over eating	___ Mood swings

___Lack of support ___Difficulty concentrating ___ Difficulty focusing ___Overspending
___Gambling ___ Grief / Loss ___Dissociation/loss of time ___Depersonalization
___Health Problems ___ Chronic pain ___Life changes/stages ___Financial concerns
___My appearance ___ Fear of Future ___ Perfectionism ___Spiritual concerns
___Career Choices ___Weight ___Shame ___Relationship issues
___Flashbacks ___Avoidance ___ Panic/anxiety attacks ___ Trauma event(s)
___Exploitation ___Abuse (of any kind) ___ Repetitive thoughts __Repetitive behavior
___Gaming ___ Binging / Restricting food Other: _____

Circle any significant life changes or stressful events that you have experienced recently:

Death of a spouse/partner Marriage Problems Divorce
Death of a family member Family Issues (with children/parents/siblings/in-laws)
Major illness/injury of self Financial issues Move to another city or state
Major illness/injury of relative Legal Problems Bad break up
Job dissatisfaction Loss of job Other _____

Religious/Spiritual/ Faith Information:

Do you attend Church, Synagogue or other religious services? Yes No If yes, how often_____
What is your perception of God/Higher Power?_____
_____
Describe briefly your relationship with God_____
_____
Describe your religious/spiritual upbringing_____
_____
Describe any specific religious/spiritual beliefs/values you feel strongly about _____
_____

<u>Cultural Preferences</u>

What are the most important aspects of your background or identity? _____
_____

Are there any aspects of your background, culture, identity, race, ethnicity, religion, or sexual orientation that are causing any concerns or difficulties for you? Yes No
If yes, please explain _____

<u>What do you consider to be some of your strengths?</u>

_____

_____

What do you consider to be some of your challenges or barriers to treatment?

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

Consent for evaluation and treatment. –

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: _____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor : _____ DOB _____ Relationship: _____