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EASTMAN COUNSELING SERVICES
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CLIENT INTAKE INFORMATION

Date:_____

I. Identification Information

Name:_____ Date of Birth:_____ Age:_____

Street or Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ SS#:_____

Cell Phone:_____

Employer/School:_____ Occupation/Studying:_____

How long with Employer/School?_____ Education Completed:_____

How did you hear about me or Eastman Counseling Services?_____

In an emergency, who can we call?_____ #_____

II. Family Information

Relationship Status: [ ] Single [ ] Married [ ] Partnered [ ] Divorced [ ] Widow/Widower
If married or partnered, length of relationship:_____

This is my [ ] 1st [ ] 2nd [ ] 3rd [ ] 4th marriage/partnership

Names of children and their ages:_____
_____
_____

List everyone who lives with you:_____
_____

How do you get along with your present spouse or partner?_____
_____
_____

How do you get along with your children?_____

_____

_____

_____

Are your parents [ ] still married [ ] divorced [ ] never married [ ] widowed [ ] deceased

Where are you in the birth order of siblings in your family?_____
Please list names and ages of your siblings:_____

Please indicate if you have a family history of:

Depression	Suicidal Attempts	Anxiety
Eating Disorders	Mental Illness	Physical Abuse
Sexual Abuse	Emotional Abuse	Alcoholism/Drug Addiction

Chronic Illness (please explain)_____
Other:_____

Please indicate any of the following that you have experienced:

Death of Mother	Your age at occurrence:_____
Death of Father	Your age at occurrence:_____
Death of Child	Your age at occurrence:_____ Child's Age_____
Death of Sibling	Your age at occurrence:_____ Sibling's Age_____
Desertion by mother as a child	Your age at occurrence:_____
Desertion by father as a child	Your age at occurrence:_____
Divorce of parents	Your age at occurrence:_____

How do (did) you get along with your family of origin members:
Mother?_____
Father?_____
Siblings?_____

III. Medical Information

Primary Care Physician:_____Tel. No._____

Major (or chronic) Operations/Illnesses/Injuries_____

_____

_____

_____

Current Medications Dosage(s) Frequency For What Symptom? Prescribing Physician

_____
_____
_____
_____

Do you consume any alcohol? [ ] Yes / [ ] No
[ ] Less than 1x/mo [ ] 1-3x/mo [ ] 1x/week
[ ] Several x's/week [ ] Every day
[ ] Beer [ ] Wine [ ] Hard Liquor (check all that apply)

Do you use any street drugs or misuse prescription drugs? [ ] Yes / [ ] No
Names of Drug(s):_____
Frequency of Use:_____

Have you ever been in a drug or alcohol treatment program? [ ] Yes / [ ] No
[ ] Inpatient [ ] Outpatient
Where? How Long? Outcome?

_____
_____
_____

IV. Problem Checklist

Do you feel you are being affected by any of the following?

[ ] Anger/Temper
[ ] Phobias, Anxiety or Panic attacks
[ ] Obsessive thoughts or compulsive behaviors
[ ] Depression
[ ] Nightmares
[ ] Sleep problems
[ ] Change in appetite or eating habits
[ ] Weight gain or loss
[ ] Increase or decrease in sexual desire
[ ] Problems with sexual functioning
[ ] Suicidal thoughts or attempts
[ ] Other self-harming behavior
[ ] Illness or injury of yourself
[ ] Chronic pain
[ ] Illness or injury of a family member
[ ] Death of a close friend or family member
[ ] Parenting problems
[ ] Separation or divorce
[ ] Other (please list)_____

[ ] Problems in the workplace
[ ] Job change
[ ] Hearing voices or having hallucinations
[ ] Paranoid thinking
[ ] Emotional abuse
[ ] Physical abuse
[ ] Sexual abuse
[ ] Attention/concentration problems
[ ] Restlessness/hyperactivity
[ ] Alcohol or drug addiction
[ ] Eating disorders
[ ] Memory problems
[ ] On-going litigation (lawsuits)
[ ] Criminal behavior
[ ] Gambling
[ ] Shoplifting
[ ] Relationship/marital problems

V. Treatment Information

Please describe the main concern(s) that have prompted you to see me now:

How long have you had these concerns?

Please describe what you would like to be different in your life when you are done with therapy.

Have you ever received psychological or psychiatric counseling before? [ ] Yes / [ ] No
When? From Whom? Purpose?

Have you ever been prescribed medication for a psychiatric or emotional problem?[ ] Yes / [ ] No
When? Prescribing Clinician? What Medication? For What? Results?

Have you ever been hospitalized for a psychiatric or emotional health reason? [ ] Yes / [ ] No
When? Where? For What Reason? Outcome?

VI. Resources

What kind of support system do you have?

Does religion or spirituality play an important part in your life?