IP.COUNSELING

Put Your Life Into Balance

Client Intake Form: Adult

Date: _____

Please fill out the following information.

Client Name:_____ Client Age:_____ Client Birthdate:_____

Client SSN:_____

Address:_____ City: _____State_____

_____ Zip: _____Email: _____

Cell: _____ May we leave a message via phones?: Yes No

Home: _____ May we contact you via email?: Yes No

Gender/Gender Identity: _____ _____

Emergency Contact Information:

Name:_____ Relationship: _____

Phone: _____

Therapy/Counseling History:

Are you currently in therapy or counseling? Yes No

Counselor Name: _____ Agency Name: _____

Reason: _____

_____

_____

Phone:_____ Permission to Contact: Yes No

Have you ever been in counseling before? Yes No

When:_____ Agency Name: _____

Reason: _____

_____

Employment

Place of employment: _____

Medical History

Physician Name: _____ Phone Number: _____

List any health issues or medical diagnoses, or disabling conditions:

_____

_____

_____

_____

Medication Name	Dosage (mg/daily)	Dates Taken	Purpose

Military Service

Are you currently serving or have you served in the military? ____Y ____N If so, please describe:

_____

What brings you to counseling or coaching?

_____

_____

_____

Please do your best to express to me *what it feels like to be you* on any given day...

_____

_____

_____

_____

_____

What changes do you want to see as a result of treatment?:

_____

_____

_____

_____

Client's Relationship Status:

Please describe any past or current relationship status:

_____

_____

Concurrent Stressors and Symptoms:

____Depressed Mood
____Worry/rumination
____Feelings of shame
____Feelings of Guilt
____Fatigue/Low Energy
____Poor Concentration
____Irritability/Anger
____Substance Abuse
____Anxiety
____Hopelessness
____Emptiness
____Social Isolation
____Worthlessness
____Loss of pleasure in hobbiea
____Thoughts of Suicide
____Appetite changes
____Weight Loss
____Weight Gain
____Intense Crying
____Recurring thoughts/ images
____Feelings of Panic
____Difficulty controlling emotions
____Disorganized Thoughts

____Worthlesness
____Disordered Eating
____Chronic Pain or disease
____Financial Problems
____Sexual trauma
____Employment Stress
____Lack of Emotional Support
____Loneliness
____Infidelity
____Childhood trauma
____Hypersensitivity
____"zoning out"
____Physical Abuse
____Sexual Abuse
____Emotional/Mental Abuse
____Seeing or hearing unusual
____Fears/Phobias
____Sexual dysfunction
____Fainting
____Compulsions
____Developmental Disabilities
____Body Pains or problems
____Temper Outbursts/rage
____Suicide attempts/dates:

____Divorce or Separation
____Problems with attachment
____Nightmares
____Communication problems
____Losing time/blackouts
____Sleep too much
____Sleep too little
____Recent traumatic event
____Fertility struggles
____Helplessness
____Feeling disconnected
____Life transition
____Seizures
____Emotional numbness
____Death/Loss
____Loud, Negative Thoughts
____Memory Problems
____Uncontrolled emotions
____Unresolved Grief
____Problems with relation-ships (add):

____Other (add):

Has anyone ever told you that they were worried you had a problem with alcohol and/or drugs? Please explain: _____

Family History of Mental Illness and/or traumatic events (known or suspected):

_____

_____

_____

Client Signature: (by signing below I am stating that all above info I know to be true at this time):

_____ _____

Client Signature **Date**