The Listener

Client Intake Form

This information will remain confidential.

DATE: _____

CLIENT NAME: _____DOB _____

AGE: _____GENDER: Male___ Female___ Nonbinary___Transgender___

OCCUPATION: _____EMPLOYEER:_____

ADDRESS _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE_____ OK to phone? Y ☐ N ☐

Ok to leave a message? Y ☐ N ☐

CELL PHONE_____ OK to phone? Y ☐ N ☐

Ok to leave a message? Y ☐ N ☐

WORK PHONE_____ OK to phone? Y ☐ N ☐

Ok to leave a message? Y ☐ N ☐

EMAIL: _____

PRESENTING PROBLEM: (be as specific as you can: When did it start, how does it affect you?)_____

_____

_____

_____

GOALS OF COUNSELING:

Please describe your specific goals for therapy:

_____

AREAS OF CONCERN OR STRESS: (USE AN X FOR CURRENT CONCERNS; A CIRCLE FOR PAST CONCERNS)

PERSONAL OR RELATIONAL CONCERNS:

_ Needing to be heard

__ Grief/Mourning/ Loss
__ Depressed
__ Anger or difficulty controlling temper
__ Stressed
__ Loneliness
__ Anxiety (Specific: _____)
__ Guilt
__ Physical problems
__ Sleeping problems
__ Drug Use
__ Financial difficulties
__ Employment difficulties/stress
__ Alcohol Use
__ History of traumatic experiences
__ Sexual abuse __Rape
__ Incest __Assault
__ Use of internet
__ Pornography
__ Sexual Concerns
__ Arguing or handling conflict
__ Infidelity
__ Emotional abuse by partner
__ Physical abuse by partner
__ Lack of emotional support
__ Problems with relatives
__ Communication Issues
__ Fear (Specify_____)
__ Nightmares:
__ Weight change
__ Panic Attacks
__ Lack of concentration
__ Eating concerns/body image
__ Integration issues
__ Spiritual or Religious Issues Explain: _____

LIFE ADJUSTMENT:

__ Divorce or Separation
__ Newly married or remarried
__ Stepfamily with children
__ Moving to new location
__ Parenting a newborn
__ Being a single parent
__ Addition of a parent to household

__ Other adjustments - Please specify:
_____

FAMILY CONCERNS:

__ Custody or visitation problems
__ Parent / Child Conflicts
__ Major difficulties with child or teen
__ One or more family members not getting along
__ Adolescence Issues
__ Child(ren) having difficulty with divorce or new marriage
__ Emotional abuse of child (ren)
__ Physical abuse of child (ren)
__ Sexual abuse of child (ren)
__ Difficulty letting children grow up

PLEASE INDICATE HOW THE FOLLOWING SYMPTOMS/PROBLEMS/COMPLAINTS ARE EFFECTING YOU: 1) LITTLE EFFECT 2) SOME EFFECT 3) MUCH EFFECT 4) SIGNIFICANT EFFECT (LEAVE BLANK IF NO EFFECT)

____Eating habits/Appetite: eating more, eating less
____Binge; purge

____Sleep: Trouble falling asleep; Trouble staying asleep; Trouble waking up; Average # hours sleep_____ #Naps__

___Decreased energy/Fatigue
____Sexual functioning
____Loss of interest in activities
____Tearfulness
____Hopelessness/Helplessness
____Decreased attention span
____Inattentive/Distractible
____Memory: Long term; short term
____Difficulty planning ahead
____Shame
____Dis-heartened
____Disconnected
____Confusion
____Sad

____Yearning
____Annoyed
____Avoiding
____Spending sprees
____Rapid heartbeat
____Phobia
____Sweating
____Trouble Breathing
____Flashbacks of traumatic events
____Nightmares
____Racing thoughts
____Impulse control - hyperactive
____Mood changes
____Anxious/nervous
____Worry/fear/afraid
____Hearing voices
____Seeing things that are not there
____Stealing
____Anger outbursts

RATE HOW THE PROBLEMS/SYMPTOMS/COMPLAINTS ARE IMPACTING AREAS OF FUNCTIONING: 1) MILD 2) MODERATE 3) SEVERE (LEAVE BLANK IF NO EFFECT)

____Marriage/Relationship
____Work/School
____Family
____Friendships
___ Financial Situation
____Physical health
___Social interests
____Leisure Activities

_Cl
____Clubs /Group memberships
____Legal
____Housing
____Attending to daily living activities (shower, grooming, self care, etc)

____Other_____

PLEASE ADD ANYTHING IN THE SPACE PROVIDED ANY OTHER INFORMATION YOU WOULD LIKE ME TO KNOW ABOUT YOU AND YOUR SITUATION.

_____

_____

_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Phone #(s) _____

PATIENT NAME:_____DATE:_____

PATIENT SIGNATURE: _____