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: __________________________________ **GROSS YEARLY INCOME OF HOUSEHOLD:** <$25,000 <$50,000 <$75,000 >$75,000

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

____

____

____

RELATIONSHIP STATUS:

Current Relationship status: _____Single_____Partnered_____Marrried_____Divorced_____Seperated_____ _____Widowed

If single, how long have you been single? ___________
If partnered or married, how long have you been? ___________
What is your partner or spouse's name? ________________________
If married, how many times have you been married? _________
If separated or widowed, how long ago did that occur? _________

CURRENT HOUSEHOLD MEMBERS (Include Yourself):

Name	Age	Relationship to you

FAMILY

Do you have children? Yes No If yes provide information below:

Name	Age	Lives at	(Circle one)
			Biological / adopted / step-child
			Biological / adopted / step-child
			Biological / adopted / step-child

Family-of-Origin

Mothers Age: ______ If deceased, how old were you when she died? _____
Father's Age: ______ If deceased, how old were you when he died? _______
Number of Brothers: ____ Their ages: __________________
Number of sisters: ____ Their ages: _________________ Are you adopted? ___________

Briefly describe your relationship with your father:

___

___

Briefly describe your relationship with your mother:

___

___

Briefly describe your relationship with your step parents:

___

___

List family members with mental health past:

___

EDUCATION:

GED HS Diploma Associate's/Technical Degree Bachelor's Degree Post-Graduate

If degree applies please specify major ____

RELIGIOUS / SPIRITUAL BACKGROUND:

Do you consider yourself religious, spiritual, both, neither or agonist or atheist? __________________

Were you affiliated with any church / religion growing up? Yes___ No____

If so what Church or Religion?__________________________

Are you currently affiliated or attending a church/religion now? Yes___ No____ What Church or Religion? _____________

Describe your religious / Spiritual upbringing if any?

____

____

____

Medical history:

Do you have any significant health/medical issues? Yes___ No___ If yes, what is/are the health issue(s) and are you limited in any way?

____

____

____

Date of last medical exam: __________________ Medical doctor & phone #: ______________________________________

Have you ever had a trauma to head, unconsciousness, or seizures? Yes___ No____

If yes, explain:____

Counseling History: Have you attended counseling previously? Yes ____ No_____

When (Specify Dates):	Where and with whom:	Presenting issues at that time:	Diagnosis given:

Are you currently in therapy or counseling with anyone? Yes____ No____

Whom ________________________________ Where ____

How long ______________________________________ Reason ____

Describe the experience ____

Have you ever been hospitalized for any mental health reasons? Yes___ No____

When	Where:	Reason:	Presenting problem / Diagnosis

Psychotropic medications: Are you currently taking any psychotropic medications? Yes___ No___

(Specify current & past meds)

Medication	Condition	Dosage	Dates of usage	Side effects	Physician

ALCOHOL / SUBSTANCES / DRUG USAGE:

Do you currently use alcohol, marijuana or other substances or drugs? Yes_____No_____

Describe the use of substances, drugs, alcohol, marijuana (type, amount, frequency):
____

When did you start using these substances / drugs?
____

What has your past use of alcohol, substances or drugs been like?
____

Coffee (#______cups/daily)

Cigarettes (#______per day)

Marijuana (#______joints, bowls, dabs, bong rips, vape pen drags / daily_____or weekly_______

Alcohol (#_______drinks/daily________or weekly_______) Date last drank:______________________

PLANT MEDICINE USAGE:

Do you partake in plant medicine: Yes_____No_____

What Plant medicine?

Describe your use (amount, frequency):

What does your past relationship with plant medicine look like?

SUICIDE RISK: Have you ever attempted suicide? Yes____ No____

If yes, when? _________________________________ How many times? ____

Have you recently had thoughts of suicide? Yes____ No____

How or what did you plan to do? ____

What were the circumstances at the time? ____

Has anyone close to you ever attempted or committed suicide? Yes____ No____

If yes, who, how, and when? ____

ABUSE HISTORY: Have you ever been physically, emotionally, or sexually abused? Yes____ No____

If yes, briefly explain (who, what and when): ____

____

____

SUPPORT SYSTEMS:

Do you have people that you can turn to for support? Yes____ No____

If yes, who? ______________________

____

PRESENTING PROBLEM:

What do you hope to achieve or accomplish through counseling? ____

____

What have you tried that has been helpful? ____

If there are multiple current issues going on, what concerns do you hope to deal with initially?

____

GOALS OF COUNSELING:

Please describe your specific goals for therapy:

____

____

If applicable, Please describe your partner's, spouse's or family member's specific goals for your therapy:

____

____

How will you know when therapy is no longer needed in your life?

____

____

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 following 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
__ 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_________________

WHAT GIVES YOU MOST JOY OR PLEASURE IN YOUR LIFE:

____

____

____

WHAT ARE YOUR MAIN WORRIES AND FEARS:

____

____

____

WHAT DO YOU IDENTIFY AS YOUR STRENGTHS:

________________________ _________________________ _________________________ _____________________

________________________ _________________________ _________________________ _____________________

________________________ _________________________ _________________________ _____________________

WHAT DO YOU IDENTIFY AS YOUR WEAKNESSES:

________________________ _________________________ _________________________ _____________________

________________________ _________________________ _________________________ _____________________

________________________ _________________________ _________________________ _____________________

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

____

____

____

____

____

____

REFERRAL INFORMATION

How did you hear about us?

____ Referred by a friend

____ Web Site / Facebook Post

Other ____

May I have your permission to thank the person who referred you to me? Yes____ No____

EMERGENCY CONTACT INFORMATION

Name ____ Relationship ____

Phone #(s) ____

PATIENT NAME:____DATE:___________________

PATIENT SIGNATURE: _____________________________________