CLIENT INTAKE FORM

General Information

Today's Date: ________________________

Client Name: ____

Preferred Name: ____

Pronouns (e.g., she/her/hers, he/him/his, ze/zir/zirs, they/their/theirs): ________________

Birthdate (Mo/Day/Yr): _____________________________

Marital Status (circle one): Single Married Divorced Widowed Other: ____________

Current Relationship Status: ____

Address & Contact Information

Home Address: ____

Home Phone: __________________
Okay to call: □Yes □ No
Okay to leave message: □Yes □ No

Cell Phone: ____________________
Okay to call: □Yes □ No
Okay to leave message: □Yes □ No

Emergency Contact Information

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Relationship to Emergency Contact: ____

May we contact your designated Emergency Contact in case of an emergency? □Yes □ No

How did you find Kristen Helms, LCSW?

Psychology Today Internet Search Referral _________ Other ________

If working, please give occupation and name of employer (address and phone not needed)

____

If a student: □Full time □Part time School Attending: _________________________

Do you consider yourself to be religious or spiritual? □Yes □ No

Is yes, please provide a brief description of what that means to you

____

____

Please describe the people in your life who play a supportive or influential role

____

____

Mental Health

List other therapy or counseling you have received in the past or are receiving now:

Therapist's Name	Address	Approximate Dates

Do you make use of any community-based support groups (12 step programs, AA, NA, social support)? □Yes □ No
If yes, please explain:

____

____

____

In your lifetime, have you ever been in a state hospital or psychiatric facility? □Yes □ No

If yes, please explain:

Medical Information

Do you have any chronic medical conditions? □Yes □ No

If yes, please explain

Please list any medications you are taking below

Medication	Strength	How Many	How Often

What is the name of your current physician?

Have you had a serious illness in the last 12 months? □Yes □ No

If yes explain:

Have you ever suffered a head injury or lost consciousness? □Yes □ No

If yes, when and how?

____

____

____

Suicide Ideation: (Based off of Columbia-Suicide Severity Rating Scale: C-SSRS)

	Today		Past Month		Lifetime	
1. Wish to Be Dead Have you wished you were dead or wished you could go to sleep and never wake up?	Yes	No	Yes	No	Yes	No
2. Current Suicidal Thoughts Have you had any thoughts about killing yourself?	Yes	No	Yes	No	Yes	No
If you answered **NO** to questions **1 and 2** please skip questions 3-5 and move directly to Current Symptoms Checklist						
3. Suicidal Thoughts w/ method Have you been thinking about how you might kill yourself?	Yes	No	Yes	No	Yes	No
4. Suicidal Intent w/out specific plan Have you had these thoughts and had some intention of acting on them?	Yes	No	Yes	No	Yes	No
5. Intent with Plan Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	Yes	No	Yes	No	Yes	No

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs?
□Yes □ No
Please list how much and how often you drink and/or take prescription or non-prescription drugs:

____

____

____

Do you have a past that involves using drugs or alcohol? □Yes □ No
Please briefly describe

Have you ever felt you would like to cut down on your substance use? □Yes □ No

Have you ever been arrested for a DUI, or drug use? □Yes □ No
Please briefly describe circumstances below:

Current Symptoms

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad or crying	0	1 2 3	4 5 6 7	8 9 10
2. Guilty feelings	0	1 2 3	4 5 6 7	8 9 10
3. Changes in sleep patterns __Difficulty falling asleep __Difficulty staying asleep __Can't get up in a.m. __Nightmares	0	1 2 3	4 5 6 7	8 9 10
4. Change in weight/eating __Increase __Decrease	0	1 2 3	4 5 6 7	8 9 10
5. History of restrictive eating, dieting or purging	0	1 2 3	4 5 6 7	8 9 10
6. Insecurity or inferiority	0	1 2 3	4 5 6 7	8 9 10
7. Loss of interest in pleasurable activities	0	1 2 3	4 5 6 7	8 9 10
8. Anxious, nervous or panicky feelings	0	1 2 3	4 5 6 7	8 9 10

9. Avoiding places or situations	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
10. Repetitive thoughts or behaviors	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
11. Change in work habits __Increase __Decrease	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
12. Change in spending habits __Increase __Decrease	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
13. Anger or temper problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
14. Flashbacks or intrusive memories	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
15. Physical problems, pain or illness	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
16. Sexual worries or problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
17. Brain fog, fuzzy thinking or dissociation	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
18. Memory problems	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**
19. Confused or disorganized thoughts	**0**	**1 2 3**	**4 5 6 7**	**8 9 10**

Additional Information

Please name one personal strength? ____

Please name one personal weakness? ____

What do you hope to accomplish during your time in therapy?

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