CLIENT INTAKE FORM

Client Name:

Date of birth:

Address:

If not the client, name of person filling out this form:

Presenting Issues/ Concerns (behavioral, emotional, relational, academic):

Is this the first time seeking counseling? Yes No

Most recent visit (approximate date is fine):

Provider Name, Address, Phone:

History of Trauma (sexual/physical), Loss, Grief, Significant Family Changes:

Within past 1-2 years:

Prior to 2 years:

Current Functioning at School:

Name of School and grade:
IEP or 504: yes / no ED/LD services:

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Academic Strengths/Weaknesses:

Behavioral Issues:

Peer Relationships:

Current Functioning at Home:

How does client get along with family members:

How does client react to stressful situations:

How does client handle being redirected/consequences:

What is the most stressful time of day for client (ie: morning, homework, bedtime):

Parenting Strengths/Weaknesses:

Parenting style (same or different between parents):

Do you present as a team? Do you back one and other up even if disagree?

Disagree in front of client? Undermine other's authority?

CLIENT INTAKE FORM

Mental Health/ Substance Abuse/Treatment History:

For Client:

For Family Members:

Current or History of Self-Harm, Suicidal Thoughts, Harm to Others:

Developmental Issues: (prenatal, neurological, milestones)

Client Functioning:

Changes in energy level?

Changes in eating/sleeping patterns?

Changes in interest regarding activities once enjoyed?

What extra-curricular activities does client participate in?

Changes in peer group/isolating from friends?

Substance Use/Abuse or Parental Suspicion?

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How is client with following directions from parents/authority?

Any legal involvement?

Medical Issues (circle below)**:**

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness		

Explain Above Noted Concerns**:**

Other Medical Diagnosis**:**

Medications:

Prescribing Physician and contact information:

Family Functioning:

Describe Family Atmosphere in 3 words:

What is your family communication style?

How does your family handle conflict?

What does your family do for fun?

Do you have a support system in the area (ie- church, extended family, friends)?

Are there any significant family/marriage concerns that may be impacting your child or the family system?

Is there anything else you would like me to know?

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