New Client Intake Sheet Valerie Hamaker, MA, LPC, SATP

**Client** **Information**

**BASIC** **INFORMATION**

Name (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth

Address:

Please provide contact phone number(s) and indicate your preferred number.

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Leave a message? \_\_\_ yes \_\_\_ no preferred? \_\_\_ yes \_\_\_ no

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? \_\_\_ yes \_\_\_ no preferred? \_\_\_ yes \_\_\_ no

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? \_\_\_ yes \_\_\_ no OK to call? \_\_\_ yes \_\_\_ no

E-mail: OK to E-mail? \_\_\_ yes \_\_\_ no

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have your permission to thank the person who referred you? \_\_\_ yes \_\_\_ no

**RELIGIOUS** **AND** **SPIRITUAL**

Do you consider yourself spiritual? Yes No religious? Yes No

Comment?

Do you currently express this spirituality through religious practice? Yes No

Comment?

Would you like spirituality included in your counseling? Ye No

**BACKGROUND** **AND** **PRESENTING** **PROBLEM**

Occupation (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_ If married, how long? \_\_\_\_\_\_

If you have been married before, please provide dates for marriage(s) and divorce(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe briefly the problem or situation, which led you to seek our services at this time:

How long has this been a problem? \_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced this type of problem before? \_\_\_\_\_\_\_\_\_\_ If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had counseling before? \_\_\_\_\_\_\_\_\_ If so, when and why?

Was it helpful? \_\_\_\_\_\_ If not, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had medication prescribed for psychiatric or emotional difficulties? \_\_\_\_\_\_\_\_\_\_\_\_\_

If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have any other biological relatives had problems similar to yours, or had any other psychiatric or emotional difficulties? \_\_\_ yes \_\_\_ no

If so, which relatives and what kind of problems?

Presenting problems: (check all that apply-if attending couples counseling please put your initials next to the problems that apply)

* very unhappy
* irritable
* temper outbursts
* withdrawn
* daydreaming
* fearful
* worry
* overactive
* slow
* short attention span
* distractible
* lacks initiative
* undependable
* social problems
* crying spells
* hair pulling
* impulsive
* Stubborn
* panic attacks
* lying
* mean to others
* destructive
* trouble with the law
* health problems
* self-mutilating
* stressed out
* relationship problems
* shy
* strange behavior
* strange thoughts
* physical abuse
* sexual abuse
* parenting problems
* Stealing
* repetitive/ritualistic behaviors
* grief
* employment problems
* financial stress
* legal problems
* violence
* eating problems
* sleeping problems
* sexual problems
* drug use
* alcohol use
* suicidal thoughts
* homicidal thoughts

Explain:

What are your goals for treatment?

Is there anything else you feel is important for your counselor to know?