HYGEIA COUNSELING SERVICES[SM]

a d u l t   p s y c h o t h e r a p y

CLIENT INTAKE FORM (Regular Version)

Proper treatment requires as much historical information as possible. Please fill this out to the best of your abilities. Completing this outside of session will maximize our therapy time. We will likely go over some of the answers. Please feel free to ask questions or to write "I decline" for information you would rather not reveal.

Name:____ Date of Birth:_______________

Psychiatric History

Prior Counselor/Psychiatrist____________________ | Prior Counselor/Psychiatrist________________________

Dates of Treatment____________________________ | Dates of Treatment_______________________________

Treated for:_________________________________ | Treated for:______________________________________

Type of Treatment (circle one) | Type of Treatment (circle one)

outpatient inpatient group medication other_______ | outpatient inpatient group medication other_______

Please continue psychiatric history on back of page as needed.

Has anyone in your family ever been diagnosed with or thought to have symptoms of any mental disorder? If so, whom and what illness? Any suicide attempts by family members?

Psychosocial History

Marital Status (circle one): married domestic-partner divorced separated single

Children's names & ages (if any):____

Please list people who are emotionally supportive of you:______________________________________

Do you have a history of interaction with the law? If so, what:__________________________________

Highest degree you have achieved (circle one): high-school 2-yr-college 4-yr-college masters doctorate other

What are your hobbies, interests, & daily activities?:____

Name & age of parents (if deceased, cause & age at death):_____________________________________

Nature of relationship with parents (past & current):____

Sibling's names & ages (if any):____

Work History

Please list last four job titles & dates held:

What are your career goals?

How satisfied are you with current job?

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Medication/Drug History

Names, dosage, & notable side effects of current medication:

Past psychiatric medications (including ADHD, sleep, & anti-depressants from somatic physician):

Frequency and quantity of caffeinated beverages, nicotine products, alcohol, illegal drugs, and marijuana:

Special Factors

Are you currently suicidal or homicidal?____

Do you have a history of either one?____

Are you court-ordered or otherwise required to receive treatment?______________________________

Do you have a history of self-mutilation such as cutting or burning yourself?______________________

Have you ever been diagnosed with, or thought to have, anorexia or bulimia?_____________________

Do you have weapons in your home?____

Have you ever been abused? (circle one) no sexual rape physical domestic-violence What age?__________

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