Licensed Counselors, Life Coaches, & Executive Coaches
6068 S. Apopka Vineland Road, Suite 11 Orlando, FL 32819
P: 407-355-7378 F: 407-641-8680
www.LifeSkillsResourceGroup.com

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ **Age:** _____ **Date of Birth:** _____

Gender: Male Female Transgender: M to F Transgender: F to M

Home Address: _____

Mailing Address if different than Home: _____

Email Address: _____ **May we email you? Yes No**

Best Contact Phone number: _____

Emergency Contact Name _____ **Relationship** _____ **Phone**_____

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

White/Caucasian African-American Black African Asian-American Asian or Pacific Islander Hispanic-American Latino/Latin American/Hispanic Arab-/Middle Eastern-American Arab/Middle Eastern Native American Alaskan Native Multiracial Other

Specify: _____

How much do you identify with your ethnic heritage?

Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list:

Religious preference: _____

Are you currently active in your religion?

Yes Somewhat No

Would you like to incorporate your religious/spiritual values and/or rituals into the counseling process?

Yes No I Don't Know

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ACADEMIC/ WORK BACKGROUND:

Place of employment: _____

Hours worked per week: _____ **Years with employer:** _____

Position: _____

Are you satisfied with your job? Yes No I Don't Know

Highest Educational Degree: _____

Major: _____

Are you a student? Yes No **If yes, where are you studying:** _____

RELATIONAL/ SUPPORT HISTORY:

Please indicate your current relationship status:

Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed

Other: _____

Approximately how many significant romantic relationships have you had? _____

If you are in a romantic relationship, how long have you been in this relationship? _____

Are you satisfied with your current romantic relationship? Yes No I Don't Know

Do you feel supported by your partner/spouse? Yes No I Don't Know

How would you rate the quality of your friendships?

Very Poor Unsatisfactory About Average Good Excellent

Besides family, how many people can you count on right now for friendship/emotional support? _____

FAMILY BACKGROUND:

Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student, 12; partner, M, doctor, 35):

Family Member	**Occupation**	**Age**

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Your Family's Religious/Spiritual Background: _____

How much conflict do you currently experience with your family (whether living with you or not)?

None Very little Some Moderate Strong Extreme

Who in your family do you currently feel closest to? _____

Most distant from? _____ In most conflict with? _____

PHYSICAL HEALTH:

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

When was your last physical examination? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Do you have a disability? No Yes **Specify:**

Are you presently taking any prescribed medication? Yes No

Please list all medications, the reason for which each is prescribed, name of prescribing physician (e.g.: Paxil/ social anxiety/Dr. Joseph):

Name of your primary care physician:

Are you having any problems with your sleep habits? No Yes

Are you having any difficulty with appetite or eating habits? No Yes

Have you had a significant weight change in the last 2 months? No Yes

Do you have any problems or worries about sexual functioning? No Yes

How many times per week do you exercise? _____ For how long each time? _____

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MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank for now)*

Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child

Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse Sexual abuse/assault as an adult

Other Trauma **Specify**:_____

Have you received counseling here or elsewhere before? Yes No

If yes, where: _____ When: _____ Duration: _____

What was the focus of previous counseling?

_____

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No

If yes, where: _____ When: _____ Duration: _____

What was the focus of the psychiatric treatment?

_____

Were you EVER prescribed psychiatric medications? Yes No

What medications and for what reason?

_____

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: _____

How often are you having thoughts of harming others presently? Frequently Sometimes Rarely Never

How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never

When: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: _____

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Have you ever attempted suicide? Yes No **Date(s):**_____

Have you ever been hospitalized for psychological reasons? Yes No

Date(s): _____

Have any of your family members (parents, grandparents, siblings) had psychological issues? Yes No

If so, please describe: _____
_____
_____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycotin, etc)?

Daily 3 or more times per week 1-2 times per week Weekly Monthly Less than monthly Never

Do you or does someone else think that you may need to cut down or stop using other drugs?

Yes No Maybe

PROBLEM ANALYSIS:

Briefly describe the problem you most wish help with right now:_____

How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 (not intense) 2 3 4 5 6 (extremely intense)

How much has your current problem interfered with your life in general?

Not at all A little Somewhat Moderately To a great extent

In what ways have you attempted to cope with this problem?

How many counseling sessions do you anticipate needing?

1-3 4-6 7-9 10-12 13-15 16-20 20+

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How motivated are you to resolve this problem?

Not at all A little Somewhat Moderately Extremely

Why have you decided that now is the time in your life to take action to resolve this problem?

How hopeful are you that this problem can be resolved?

Not at all A little Somewhat Moderately Extremely

List your strengths and qualities you admire about yourself:

When our work together has been successful, what differences will you notice in yourself?

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

_____ _____ _____

Client Name (print) Client Signature Date