Individual Client Intake Form

BACKGROUND INFORMATION

Client Name:_____

Date of Birth (month/day/year): _____SSN_____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Occupation: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone (optional): _____

Emergency Contact Person: _____ Relationship: _____

Emergency Contact Phone: _____

Referred by: _____

Primary Care Physician:_____

If necessary, do we have your permission to contact your primary care physician for consult & consult with other professionals as well? Yes No Please Initial _____

Are you currently or have you ever received counseling? Yes No

Have you had any previous diagnosis? Yes No

If yes, please state when and with whom? _____

Client Age: _____ Client Gender: _____ Client Ethnicity: _____

Presently Living with:		Marital Status:		Highest Education Completed:	
Parents	___	Single	___	Elementary School	___
Spouse	___	Married	___	High School	___
Roommate	___	Separated	___	College	___
Alone	___	Divorced	___	Graduate School	___
Other _____		Widowed	___	Professional School	___
		Other _____		Other _____	

If married, years of marriage: _____ Age when married: Husband _____ Wife _____

FAMILY MEMBERS

Relation	Name	Age	Occupation or Grade Level	√ if living with you
Spouse				
Father				
Mother				
Children				

Have there been any significant family events in the last year (i.e. death, serious illness, divorce, marriage, job change, domestic abuse, traumatic events, etc.)?

_____
_____
_____
_____

HEALTH INFORMATION

Do you have insurance? Yes No

If yes, what type of insurance? _____

Rate your health: Very Good ___ Good ___ Average ___ Declining ___

Recent weight change: Lost _____ Gained _____

List all present and past illnesses, injuries, or handicaps that have required medication or physical care (Please place a check next to any that you are currently experiencing):

_____
_____
_____

Medication(s) currently using:_

_____
_____

Medication(s) allergies_____

Food allergies_____

RELIGIOUS BACKGROUND (Optional)

Religious preference (i.e. Christianity): _____

Religious Place of Attendance: _____ Active Member: Yes No

Does your spouse and/or family share the same or similar religious preference? Yes No

Any religious/spiritual concerns? Yes No

Explain any recent changes or challenges in your spiritual life:

_____
_____

OTHER INFORMATION

Have you ever used drugs for anything other than medical purposes? Yes No

If married, has your spouse? Yes No

Have you ever taken any street drugs? Yes No Name of drug(s): _____

Do you drink alcohol? Yes No How often? _____

Do you have trouble sleeping? Yes No

How many hours of sleep do you average each night? _____

Circle any of the words that best describe you now:

persistent nervous impatient impulsive cautious moody sad depressed excitable shy introvert extrovert quiet loud lonely submissive self-conscious sensitive

other(s) _____

Please circle all that apply (any symptoms that you have experienced in the last 30 days):

Headaches - Nightmares - Self-injurious Behavior - Thoughts of Suicide

Stomachaches - Can't Trust Anyone - Strange Thoughts - Hopelessness

Feeling Worthless - Feel Like Crying - Panicky Feelings - Nervous

Poor Concentration - Ready to Explode - Memory Problems - Flashbacks

Hearing Voices - Seeing Things - Feeling Out of Control - Always Worried

Startled Easily - Appetite Problems - Loss of Interest (i.e. hobbies, sex, etc.)

Why am I so different? - People are Watching Me - Anger/Temper

Obsessiveness - Stress - Excessive Fear - Unexplained Aches/Pains

Compulsions - Problems Sleeping - Under-eating/Overeating

Any change in daily living skills (work, school, daily activities)?_____

Other (Please Explain) _____

In your own words please briefly describe the main problem(s) which prompted you to seek counseling with Higher Ground at this time:

_____

_____

Is there anything else which you believe might be important for your counselor to know at this time? _____

_____

_____

What do you hope will change as a result of coming to counseling?

_____

_____

_____

Please note that by signing below you are recognizing that the above information is as accurate and current as possible. You have received a copy of your rights, and consent to treatment by Higher Ground Life Services.

Signature: _____ Date: _____

CANCELLATION POLICY

Our goal is to help people to heal.
Your faithfulness in keeping your appointments allows us
to achieve this goal.

When clients miss 2 or more appointments,
Higher Ground Counseling may cancel future appointments
to make room for others who need our services.

Your progress and recovery are dependent upon
your consistency in keeping your appointments.