



Catholic Counseling Service

CLIENT INTAKE FORM

Client Contact Information

Date of First Session _____

Name: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Home Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

Reason for Counseling

Please explain why you are seeking counseling.

How did you hear about us, or who referred you? _____

Have you received counseling or therapy before? Yes No

If yes: Psychiatrist Psychologist Social Worker Minister Counselor

Was it helpful? Yes No

Explain:

Client Information

Date of Birth: _____ Employment: _____

Check the highest level of schooling that you have completed:

Elementary School High School College Post College Trade School GED

Marital Status: Single Cohabiting Married Separated Divorced Widowed

Persons living with you:

Name	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Presenting Problems

Please describe your current symptoms.

- Addictions
- Anger/Temper Problems
- Anxiety
- Behavior Problems
- Crying
- Cutting/Hurting Yourself
- Depression
- Eating Problems
- Fears
- Hearing Voices/Seeing Things
- Homicidal Thoughts
- Inability to Focus/Concentrate
- Not Accomplishing Work/Tasks
- Obsessive-Compulsive Behaviors
- Pornography Problems
- Panic Attacks
- Relationship Problems
- Sexual Compulsions
- Sexual Problems
- Sleep Problems
- Suicidal Thoughts

If your symptom is not listed, please describe:

Have any other family members had similar problems? Yes No

If yes, who? _____

Medical History

When was your last physical exam? _____

Physician's Name: _____ Physician's Phone Number: _____

Have you ever been diagnosed with a mental disorder? Yes No If yes, what: _____

Are you currently under treatment by a psychiatrist? Yes No

If yes, Psychiatrist's Name: _____ Psychiatrist's Phone Number: _____

Please list medications below.

Medication	Dose/Frequency	Length of Time	Condition Being Treated
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List health conditions or illnesses you have had. Note approximate date or age at time of condition/illness.

Health Condition or Illness	Age or Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Is there a family history of mental illness, attention problems, or addiction? Yes No

If yes, please explain: _____

Your parents' marital status: Married Divorced Separated Other: _____

Please list your children's names, ages, and occupations (including "student"):

Name	Age	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Briefly describe the role religion and spirituality play in your life:

Do you have trouble in your relationships with others? Yes No

Are you currently in a committed relationship? Yes No

Are you currently sexually active?: Yes No

Briefly describe your work history, starting as far back as you can remember.

Have you served in the military? Yes No

Have you ever been in trouble with the law? Yes No

If yes, explain: _____

Are you involved in legal problems? Yes No

If yes: Custody Divorce/Separation Parole Probation Lawsuit Other: _____

Please check all substances used.

Type	When		How Often		
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Marijuana	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Heroin	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Hallucinogens	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Past <input type="checkbox"/> Present	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	

Have you been a victim or perpetrator of abuse? Yes No

If victim: Sexual Emotional Physical

If perpetrator: Sexual Emotional Physical