Joy Counseling and Consulting, LLC

CLIENT INFORMATION INTAKE FORM

THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL

(PLEASE PRINT CLEARLY)

Today's Date: _____

Name: _____Birthdate_____Age_____Gender _____

Address_____

City_____ State_____ Zip_____

Cell / Home Phone (___) _____Work Phone ( ) _____

Can we leave a message? Yes /No Text ? Yes/No Best Place to Leave a Message ( ) _____

Who were you referred by/how did you hear about us? _____

Level of Education: HS___College____Other___ Place/Type of Employment_____

How long? _____ If unemployed, how long: _____ what type of work did you do? _____

Marital Status (Parents if for a child) Married_____# of years____; Divorced___# of years _____;

Separated _____ # of years _____; Widowed____# of years____; Single____; Living with_____

Spouse's/Partner Name_____Spouse's/Partner's Occupation_____

CHILDREN (SIBLINGS IF FOR A TEEN)

NAME	BIRTHDATE	GENDER

In Case of Emergency Notify:_____ Phone:_____

Relationship:_____

Have you ever been hospitalized for psychiatric reasons? Yes / No If yes, what were the circumstances? Please include dates: _____

When was your last full physical exam? _____

Any physical/medical issues? _____

Sleeping issues? Yes / No How many hours of sleep do you get each night? _____

List any medications you are presently taking and dosage: _____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc) or mental health AND/OR substance abuse issues?_____

_____

How much do you drink on average? _____

What drugs have you tried and/or currently use? Last use? How often? How much?

_____

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Do you have current thoughts of suicide? Yes / No If so, do you have a plan? Yes / No

Have you *ever* had thoughts about suicide? Yes / No Homicide? Yes / No

Have you ever attempted suicide? Yes / No If yes, how many times? _____

What do you have to live for? 1) _____ 2) _____ 3) _____

Have you ever engaged in any self-harm behaviors (cutting, burning, etc.)? Yes / No - When ___

Have you or anyone else ever had concern about your eating habits? Yes / No

If yes, please explain_____

Do you have any sexual concerns? Yes / No If yes, explain _____

How often do you exercise? _____ What type? _____

What do you do for self-care? _____

How do you spend time relaxing/having fun? _____

Reasons for seeking counseling at this time? _____

_____

Have you ever been in counseling before? Yes / No For how long? _____

Was it helpful? Yes / No Please explain: _____

Is this your choice for counseling? (if no, please explain) _____

_____

Please check any of the following that you experience(d) or have concern and for how long?

___Headaches	___Nervousness	___Dizziness	___Fainting Spells
___Shyness	___Stomach Trouble	___Relaxation	___Stress
___Anxiety	___Self/Impulse Control	___Legal Matters	___Fatigue
___No Appetite	___Anger	___Memory	___Making Decisions
___Insomnia	___Nightmares	___Separation	___Energy
___Inferiority	___Take Sedatives	___Loneliness	___Self-esteem
___Bowel Troubles	___Use Alcohol	___Drug Use	___Allergies
___Suicidal	___Sexual Problems	___Work problems	___Under eating
___Over eating	___Home/Living Conditions	___Friends	___Concentration
___Temper	___Ambition	___My Thoughts	____Fears
___Parenthood	___Health Problems	___Phase of Life	___Mood Swings
___My appearance	___Future	___Sexual Abuse	___Children
___Career Choices	___Weight/Body Image	___Unhappiness	___Depression

___ Abuse (physical, verbal, sexual, emotional/psychological, spiritual, financial; neglect)

Circle any significant life changes or stressful events that you have experienced recently:

Death of a spouse/partner	Marriage/Partner Discord	Divorce/ Loss of relationship
Death of a family member	Loss of Job	Move to another city or state
Major illness/injury of self	Financial issues	Legal Problems
Major illness/injury of relative	Job dissatisfaction	
Family Issues (with children/parents/in-laws)		Other _____

Religious/Spiritual/ Faith Information:

Do you attend Church, Synagogue or other religious services? Yes / No If yes, how often_____

What is your perception of God/Higher Power?_____

_____

Describe briefly your relationship with God_____

_____

Describe your religious/spiritual upbringing_____

_____

Describe any specific religious/spiritual beliefs/values you feel strongly about _____

_____

Cultural Preferences

What are the most important aspects of your background or identity? _____

_____

Are there any aspects of your background, culture, identity, race, ethnicity, religion, or sexual orientation that are causing any concerns or difficulties for you? Yes / No

If yes, please explain _____

_____

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your weakness or barriers to treatment?

_____

_____

What would you like to accomplish during your time in therapy?

_____

_____

Consent for evaluation and treatment. –

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date: _____

In the case of a minor child, please specify the following:
Full name of minor : _____ DOB _____ Relationship: _____