Sacasa Counseling Services, LLC
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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 □ Cohabitating □ Married □ Separated □ Divorced □ Widowed

Persons living with you:

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

Presenting Problems

Please describe your current symptoms.

□ Addictions	□ Eating Problems	□ Pornography Problems
□ Anger/Temper Problems	□ Fears	□ Panic Attacks
□ Anxiety	□ Hearing Voices/Seeing Things	□ Relationship Problems
□ Behavior Problems	□ Homicidal Thoughts	□ Sexual Compulsions
□ Crying	□ Inability to Focus/Concentrate	□ Sexual Problems
□ Cutting/Hurting Yourself	□ Not Accomplishing Work/Tasks	□ Sleep Problems
□ Depression	□ Obsessive-Compulsive Behaviors	□ 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		
□ Alcohol	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Prescription Drugs	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Marijuana	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Heroin	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Cocaine	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Hallucinogens	□ Past □ Present	□ Daily	□ Weekly	□ Monthly
□ Other: _____	□ Past □ Present	□ Daily	□ Weekly	□ Monthly

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

If victim: □ Sexual □ Emotional □ Physical

If perpetrator: □ Sexual □ Emotional □ Physical