Confidential Client Intake Form

Today's Date_____

Please note that information requested on this form is confidential and not be released to anyone without your permission or it is ordered by a court of law.

SECTION 1: GENERAL INFORMATION

Name _____ DOB _____ AGE _____

SEX □ M □ F Address _____

City _____State _____ Zip _____

Home/Cell Phone (circle one) _____MSG OK? □ Yes □ No

Work Phone _____MSG OK? □ Yes □ No

□ Yes, I give permission to the Bright Hope to share any or all information concerning my appointment with the following individual(s):

_____

Email _____ MSG OK? □ Yes □ No

How would you prefer to be contacted? □ Home □ Cell □ Work □ Email

Employer _____ Length of Employment _____

Occupation/Title _____ Military Veteran □ Yes □ No

Religious Beliefs _____ Place of Worship _____

Racial/Ethnicity _____

SECTION 2: PRESENTING PROBLEMS

Briefly describe your reason for coming to a counselor at this time?

Has this concern affected your □ Relationships □ Work □ School □ Mood □ Eating □ Sleeping □ Health □ Concentration □ Anxiety □ Ability to function □ Finances

What are your goals for counseling?

What is your HOPE as a result of therapy?

brighthope COUNSELING CENTER

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Please mark all that apply:

Thoughts		Feelings		Behaviors	
❑ Suicidal thoughts	❑ Experience flashbacks	❑ Depressed mood/feel hopeless	❑ Feel lonely	❑ Explosive anger	❑ Loss of energy/fatigue
❑ Thoughts of death	❑ Fear of losing control	❑ Irritable mood	❑ Afraid to go out	❑ Cutting or burning self	❑ Acting out at home/ work/school
❑ Thoughts of hurting others	❑ Excessive Fear/worry	❑ Feel like others are against you	❑ Anxious often	❑ Using drugs not prescribed	❑ Unable to relax/hyperactive
❑ Loss of interest in things	❑ Confused easily	❑ Feel impending doom	❑ Feel angry often	❑ Drinking Alcohol	❑ Risky behavior
❑ Paranoid or obsessive thoughts	❑ Feel like in fog	❑ Lightheaded	❑ Nausea when upset	❑ Gambling	❑ Stealing
❑ Hearing voices	❑ Out of body experience	❑ Chest pains when upset	❑ Elevated mood	❑ Excessive spending	❑ Shaking when anxious
❑ Seeing things	❑ Nightmares	❑ Significant mood swings	❑ Shortness of breath	❑ Isolate from others	❑ Difficulty in relationships
❑ Can't concentrate	❑ Racing thoughts	❑ Elevated heart rate	❑ Feel guilty	❑ Obsessive behaviors	❑ Impulsive

SECTION 3: 911, EDUCATION & PERSONAL

EMERGENCY CONTACT (whom we can contact in case of medical/mental health emergency)

Name _____ Relationship _____

Address _____ City _____

State _____ Zip _____ Phone number(s) _____

EDUCATION

Last year of school you completed _____ Degree/Specialty _____

Referred here by _____ Relationship _____

May I thank the person who referred you (no confidential information will be shared) ☐ Yes ☐ No

Address _____ Phone _____

PERSONAL

_____Please indicate your *current* relationship status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Living with Partner ☐ Dating ☐ Spouse/Partner deceased, if so, when? _____

Spouse/Partner's Name _____ Age _____

How long in have you been together? _____ Occupation _____

Employer _____ Religious beliefs _____

Would you like information on a local church to attend? ☐ Yes ☐ No

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Describe your relationship with your spouse/partner?

Describe any past marriages or other important relationships?

SECTION 4: MEDICAL TREATMENT HISTORY/GAMBLING/SUBSTANCE & SEXUAL ABUSE HISTORY

Have you ever been *hospitalized or received inpatient treatment* for a mental health or substance abuse issue? □ Yes □ No

- If yes please explain including year, facility, length of stay, reason for seeking inpatient care.

Have you ever received *other mental health services* such as outpatient psychiatric care or counseling of any kind? □ Yes □ No

- If yes please explain including year, frequency of visits, practitioner name, what you were being treated for/diagnosis, what type of treatment was given.

Rate your physical health □ Good □ Average □ Poor

Please describe any current or past health problems? _____

Date of last examination_____ Phone # _____

Primary Care Physician's (PCP) Name _____

Address _____ **Can I contact your PCP? □ Yes □ No**

Current medication? (include dose, frequency and who prescribed it)

Please list any medication that you have had a bad reaction or to which you are allergic?

Please indicate any significant family medical history _____

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Gambling

Do you gamble? ☐ Yes ☐ No
Have you ever felt the need to bet more and more money? ☐ Yes ☐ No
Have you ever had to lie to people important to you about how much do you gamble? ☐ Yes ☐ No

Substance Use History

Alcohol	❑ Yes ❑ No	Tranquilizers	❑ Yes ❑ No	Cocaine	❑ Yes ❑ No
Hallucinations	❑ Yes ❑ No	Ecstasy	❑ Yes ❑ No	Crack	❑ Yes ❑ No
Marijuana	❑ Yes ❑ No	Synthetic Marijuana	❑ Yes ❑ No	Opiates	❑ Yes ❑ No
Tobacco	❑ Yes ❑ No	Uppers/Speed	❑ Yes ❑ No	Crystal Meth	❑ Yes ❑ No

Other:_____

Describe past (or current) substance abuse:

Abuse History

Have you ever experienced *any* form of sexual, physical or verbal abuse? (Write what you feel comfortable writing)

Have you ever been violent or had violent thoughts towards others? ☐ Yes ☐ No

If yes, please explain _____

SECTION 5: FAMILY HISTORY

Relative	Name	Current age (or age at death)	Physical/Mental health Illnesses (cause of death)	Relationship (excellent, good, fair, poor)	Are you close?	Drug abuse in your family history? Explain	Emotional abuse in your family history? Explain
Mother							
Father							
Siblings (list separately)							
Others (step-parents, step-sibling, grandparent, etc.)							

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Please describe the emotional atmosphere in your childhood home (displays of affection, parent's relationship, conflict, etc.)_____

_____

_____

SECTION 6: LEGAL HISTORY

Were you ever charged and/or convicted of a crime?

Date	Offense	Outcome	Drug(s)/Alcohol involved

Have you ever been convicted of a sexual crime? □ Yes □ No
Are you currently on probation or parole? □ Yes □ No
If so, who is your probation or parole officer? _____

Phone # _____ Fax # _____ Address _____
Do you currently have a valid drivers license? □ Yes □ No □ Restricted □ Suspended
Have you ever been involved with Child Protective Services? □ Yes □ No

Client Signature _____ Date _____

Counselor Signature _____ Date _____