THREE PEAKS
COUNSELING

Client Intake Form

First Name:_____ M.I.:_____ Last Name:_____

Birthdate:_____ Gender: _____ Age: _____

Address:_____

City:_____ State:_____ Zip:_____

Tel: Home: _____ Okay to leave message? (Circle one) Yes No

Tel: Work:_____Ext___ Okay to leave message? (Circle one) Yes No

Tel.: Cell_____ Okay to leave message? (Circle one) Yes No

Which number do you prefer us to call and leave message? (Circle one) Home Work Cell

Primary Care Physician_____ PCP Phone: _____

PCP Address: _____

PCP Fax: _____

Would you like your mental health provider to coordinate care with your PCP? Yes No

How did you hear about our practice? _____
Okay to acknowledge referral, if applicable? Yes No

In case of emergency:
Contact #1: _____

Phone: _____ Relationship to you:_____

Contact #2: _____

Phone: _____ Relationship to you:_____

Race/Ethnicity/Nationality: _____

Do you identify with a religious or spiritual tradition?

If yes, please note: _____

Sexual Orientation: _____

Employed: (circle one) Yes No Hours/Week:_____

Employer:_____ Address:_____

Position and Company:_____

Education: Highest level of education attained: _____

Please list academic or interpersonal challenges in school – elementary through university:

_____

_____

What experiences have you had in psychotherapy and personal growth? (Please indicate when and how long, when applicable): _____

_____

_____

Medical/health issues: _____

_____

_____

Medications and supplements:

_____

_____

Please list recently discontinued medications and when you stopped taking them: _____

_____

Do you drink or use recreational drug? If so, what, how much, and how often? _____

_____

_____

Who currently lives in your home? _____

_____

_____

_____

Briefly describe your family of origin: _____

_____

_____

_____

My *family of origin* has a history of: Please check all that apply

____Counseling ____Alcoholism ____ Drug Addiction ____Abuse ____Depression
____Eating Disorders ____Psychiatric Hospitalization ____ Attention Deficit Disorder
____Bipolar Disorder ____Schizophrenia ____Homicide ____Suicide
____Other (please note): _____

Symptoms/Goals

Why are you seeking counseling at this time? What are your concerns and/or goals? _____

_____ _____

_____

_____

_____

_____

How/when did your concerns begin? _____

_____

What do you consider your strengths? _____

_____

_____

Check *all* of the following that apply.
***Circle* those that you would like to address at this time.**

❑ Abuse— cruelty to animals

❑ Abuse—emotional

❑ Abuse neglect (of children or elderly persons)

❑ Abuse—physical

❑ Abuse—sexual

❑ Adoption

❑ Aggression

❑ Alcohol use

❑ Anger

❑ Arguing

❑ Anxiety

❑ Appetite increase

❑ Appetite loss

❑ Assault

❑ Attention difficulties

❑ Blended family issues

❑ Career concerns, goals, and choices

❑ Childhood issues (your own childhood)

❑ Codependence

❑ Confusion

❑ Compulsions (actions that repeat themselves)

❑ Crime victim

❑ Crying

❑ Custody of children

❑ Deaths

❑ Debt

❑ Decision making

❑ Delusions

❑ Dependence

❑ Depression

❑ Difficulty concentrating

❑ Disconnected from feelings

❑ Dissociation

❑ Distractibility

❑ Distrust

❑ Divorce, separation

❑ Drug use—over-the-counter medications

❑ Drug use—prescription medications

❑ Drug use—street drugs

❑ Eating problems

❑Employment

❑ Emptiness

❑ Failure

❑ False ideas

❑ Fatigue

❑ Fears, phobias

❑ Financial or money troubles

❑ Flashbacks

❑ Friendships

❑ Gambling

❑ Grieving

❑ Guilt

❑ Hallucinations

❑ Headaches, other pains

❑ Health

❑ Hostility

❑ Housework/chores—quality, schedules, sharing duties

❑ Hurting others

❑ Hurting Self

❑ Illness

❑ Indecision

❑Inferiority feelings

❑ Infertility

❑ Infidelity/affairs

❑Interpersonal conflicts

❑ Impulsiveness, loss of control, outbursts

❑ Impulsive spending

❑ Insomnia

❑ Irresponsibility

❑ Irritability

❑ Judgment problems

❑ Laziness

❑ Legal matters, charges, suits

❑ Life transitions

❑ Loneliness

❑ Loss of control

❑ Loss of pleasure

❑ Losses

❑ Low energy

❑ Low frustration tolerance

❑ Low income
❑ Low mood
❑ Marital/Relationship conflict
❑ Marital/relationship distance/coldness
❑ Marital/relationship different expectations
❑ Marital/relationship disappointments
❑ Medical concerns
❑ Memory problems
❑ Menstrual problems
❑ Menopause
❑ Mixed feelings
❑ Mood swings
❑ Motivation
❑ Mourning
❑ Nervousness
❑ Nightmares
❑ Obsessions (thoughts that repeat themselves)
❑ Outbursts
❑ Overeating
❑ Oversensitivity to criticism
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting/child management
❑ Perfectionism
❑ Pessimism
❑ Physical problems
❑ PMS
❑ Poor self-care
❑ Premarital counseling
❑ Procrastination
❑Putting off decisions
❑ Relationship problems (with friends, relatives, work)
❑ Relaxation
❑ Reliving difficult event(s)
❑ Remarriage
❑ Risk taking
❑ Sadness
❑ School problems
❑ Self-centeredness
❑ Self-control
❑ Self-esteem
❑ Self-neglect
❑ Separation
❑ Sexual addiction
❑ Sexual assault
❑ Sexual conflicts
❑ Sexual desire differences
❑ Sexual dysfunctions
❑ Sexual issues, other
❑ Shyness
❑ Single parenthood
❑ Sleep problems—too much
❑ Sleep problems—too little
❑ Sleep problems – nightmares
❑ Smoking/tobacco use
❑ Spacing out
❑ Spiritual, religious, moral, ethical issues
❑ Stress
❑ Stress management
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems
❑ Tension
❑ Thought disorganization
❑ Thoughts of death
❑ Tiredness
❑ Threats
❑ Transitions
❑ Violence
❑ Vomiting
❑ Under-eating
❑ Unemployment
❑ Unusual experiences
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work dissatisfaction
❑ Work problems - can't keep a job
❑ Work problems – interpersonal issues
❑ Work problems – lack of ambition
❑ Work problems - workaholism/overworking
❑ Other concerns or issues:

_____

_____