Clinical Intake Form

Name:____ Today's Date:__________________
DOB:_____________________

Referral Source:____
What would you like therapy to help you change?____
____
____

Family History ***Please circle as indicated: Y=Yes N=No DK=Don't know***
Were you raised by both biological parents? Y N *If no, by whom?_________________________
Were your biological/adoptive parents divorced/separated? Y N *If yes, how old were you?________
What # child were you in your family of origin?___________ Of how many children?________________
Were you raised with half siblings or step siblings? Y N

Did you ***OBSERVE ABUSE OF*** any family member in your family of origin? Y N DK
Were you abused/neglected in your family or origin? Y N DK
Have your father, mother, or siblings experienced any of the following problems?
Alcohol or drug abuse? Y N DK If yes, whom?_________________________________
Significant depression? Y N DK If yes, whom?_________________________________
Suicidal attempts? Y N DK If yes, whom?_________________________________
Mental illness? Y N DK If yes, whom?_________________________________
Hospitalization for
emotional problems? Y N DK If yes, whom?_________________________________
Chronic physical illness? Y N DK If yes, whom?_________________________________
Incarceration (jail/prison)? Y N DK If yes, whom?_________________________________
Anger problems? Y N DK If yes, whom?_________________________________
Have you experienced the loss by death of a:
Parent? Y N DK If yes, whom?_________________________________
Other close family member? Y N DK If yes, whom?_________________________________
Close friend? Y N DK If yes, whom?_________________________________
Outside of your family of origin, have you experienced abuse? Yes No Don't Know
Circle type of abuse: Sexual abuse Physical abuse Emotional abuse/harassment

Primary Relationships (Current or past)
Currently married? Yes No How long?__________ Living with spouse? Yes No

In committed relationship? Yes No How long?__________ Living with partner? Yes No
Have you been divorced? Yes No When?_____________
Have you been widowed? Yes No When?_____________
Have you ended committed relationship? Yes No When?_____________
Name of spouse/significant other:____

Children (Include stepchildren)

First Name	Age	Year in School/Occupation	Living with you now?
			Y N
			Y N
			Y N
			Y N
			Y N

Education

How many years of schooling have you completed?___________Diplomas/Degrees_________________
Do you now have or have you had a learning disability? Y N DK

Employment

Are you presently employed? Y N Occupation/Employer:___________________________________
Are you satisfied with your present job? Y N
Do you think your employer is satisfied with your current performance? Y N

Religion

Do you have a religious preference? Y N If yes, describe:____________________________________
Are your spiritual beliefs an important part of your life? Y N DK

Legal

Have you ever been arrested/incarcerated? Y N When?_______________________________

Stressors

Are you experiencing significant changes, loss or difficulties in the following areas?

Financial?	Y N DK
Primary relationship (family/friends)?	Y N DK
Housing?	Y N DK
Physical health of self or family member?	Y N DK
Access to healthcare?	Y N DK
Occupation/employment?	Y N DK
Legal?	Y N DK
Education?	Y N DK

Other____

Current Use of Alcohol/Drugs

Average weekly alcohol intake: None 1-3 drinks 4-8 drinks More than 8

Recreational/mood enhancing non-prescription drug use? None Daily Weekly Monthly

Drug Used? Cannabis Cocaine Painkillers Speed Methamphetamine

Other:____

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?	Y	N	DK
Lost time from school or work because of use?	Y	N	DK
Experienced a medical problem because of use?	Y	N	DK
Been fired from a job because of use and its effects?	Y	N	DK
Felt you ought to cut down on drinking or drug use?	Y	N	DK
Had people annoy you by criticizing your drinking or drug use?	Y	N	DK
Felt bad or guilty about your drinking or drug use?	Y	N	DK
Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?	Y	N	DK

My average daily nicotine use is:____

My average daily caffeine use is:____

Current Medical Care

Physician:____

Medical Diagnosis:____

Medications/Dosage:____

____

What type of exercise do you get?__________________________________ Frequency?______________

Past Mental Health/Chemical Dependency Treatment

(Include outpatient treatment and hospitalizations):

Dates (Month/Year)	Where?	Primary Therapist?