# Client Intake Assessment
## Caroline Plummer M.S., LMHC

**Date:**
**Client Name:**________________________________
**Sex**: ☐ M ☐ F
**Date of Birth:**________________________________
**Address:**__________________________________
**Phone:**
Home (___)_____- _______ OK to call you there? ☐
Cell (___)_____- ________ OK to call you there? ☐
**E-mail:**__________________________________
**Emergency Contact:**
Name:______________________________________
Phone Number: (___)_____- _______
**Guarantor Information**
Person Responsible for Payment:________________
Billing Address:______________________________
Phone Number: ☐ Home ☐ Work
(____)_____- ________
Insurance Carrier/ID Number:__________________
____________________________________________

**Reason for Seeking Counseling**
*What are your two primary goals for these therapy sessions?*
1____________________________________________
____________________________________________
2.____________________________________________
____________________________________________
*What is currently most stressful for you?*
____________________________________________
____________________________________________
____________________________________________
____________________________________________

**Current Symptoms**
*(Please check any symptoms below that you are currently experiencing?)*

☐ Affect/Energy
☐ Depressed mood
☐ Generalized fears
☐ Restless sleep
☐ Diminished energy
☐ Shortness of breath
☐ Excessive sleep
☐ Diminished interest
☐ Feeling disconnected

Other:______________________________________

*Anxiety*
☐ Increased irritability
☐ Chest pains
☐ Feelings of guilt
☐ Fears of dying

Other:______________________________________

*Sleep Disturbances*
☐ Nightmares
☐ Decreased ability to sleep
☐ Poor concentration

*Eating*
☐ Increased appetite
☐ Decreased appetite
☐ Weight gain
☐ Weight loss

Other:______________________________________

*Avoidance*
☐ Fear of specific places
☐ Fear of social situations

Other:______________________________________

*Post Traumatic Stress*
☐ Intrusive memories
☐ Hypervigilance
☐ Distress from triggers
☐ Numbing body
☐ Panic

Other:______________________________________

How often do you drink alcohol and how much do you consume?
☐ Daily__________________
☐ Weekly________________

Do you have a history of problem drinking or drug use?

☐ Yes ☐ No

*If yes, please explain:*______________________

______________________________________________

______________________________________________

______________________________________________

### Birth History

Were you born full term? ☐ Adopted? ☐

If so what age?_______

Were there any hospitalizations and/or prolonged separations from your parents before age two?____

*If so, please describe:*______________________

______________________________________________

______________________________________________

______________________________________________

Please list any complications:_________________

______________________________________________

______________________________________________

______________________________________________

### Medical Information

Primary Care Physician:______________________

Phone Number:_____________________________

Current Medications:_________________________

______________________________________________

### Medical History

Problem or Hospitalization:____________________

______________________________________________

Date:_____________

Reason:____________________________________

Results:____________________________________

Have you ever had a head injury? ☐ Yes ☐ No

*If yes, answer the following:*

Were you unconscious as a result of the injury?

☐ Yes ☐ No

How long were you unconscious?_______________

Are you currently experiencing any of the following:

☐ Frequent headaches ☐ Memory loss

☐ Difficulty concentrating ☐ Difficulty verbalizing what you want to say

When was your last complete physical by a health care professional?______________________________

Results?_____________________________________

How often do you exercise?____________________

What types of exercise?_______________________

Describe your eating patterns for a typical day?____

______________________________________________

______________________________________________

How much water do you drink daily?_____________

WOMEN:

When was your last gynecological exam?_________

Results?_____________________________________

### Self Assessment

List 3 of your Strengths for each of the following areas:

*Mental:*

1______________________________________________

______________________________________________

2.______________________________________________

______________________________________________

3.______________________________________________

______________________________________________

*Physical:*

1______________________________________________

______________________________________________

2.______________________________________________

______________________________________________

3.______________________________________________

______________________________________________

*Spiritual:*

1______________________________________________

______________________________________________

2.______________________________________________

______________________________________________

3.______________________________________________

______________________________________________

*Emotional:*

1______________________________________________

______________________________________________

2.______________________________________________

______________________________________________

3.______________________________________________

______________________________________________

*Skills/Talent:*

1. ____________________________________________
____________________________________________
2. ____________________________________________
____________________________________________
3. ____________________________________________
____________________________________________

*Social Setting:*

1. ____________________________________________
____________________________________________
2. ____________________________________________
____________________________________________
3. ____________________________________________
____________________________________________

## Social Support System

Who do you consider to be part of your emotional support system? (friends, coworkers, family, etc.)

____________________________________________
____________________________________________
____________________________________________

What changes would like to make in your interpersonal relationships?

____________________________________________
____________________________________________
____________________________________________

Does the computer play a role in your social support system? ☐ Yes ☐ No

*If yes, please explain.*

____________________________________________
____________________________________________

How many hours do you spend online:
Daily?_____________Weekly?______________

## Eating

Increased appetite: ☐ Yes ☐ No

Decreased appetite: ☐ Yes ☐ No

Weight gain: ☐ Yes ☐ No

Weight loss: ☐ Yes ☐ No

## Relationships

Please list significant relationships since age 18:

____________________________________________
____________________________________________
____________________________________________
____________________________________________

Are you currently involved in any type of intimate relationship? ☐ Yes ☐ No

*If yes, please complete the following:*

First name of partner:________________________
Partner's ethnicity:___________________________
Relationship status:

☐ Living together ☐ Married ☐ Long term dating

☐ Occasional dating ☐ New relationship

Other:_______________________________________
Length of relationship:________________________
Ages when you met: Me_____ Partner_____
Has the relationship been continuous?

☐ Yes ☐ No

*If no, how many times have you separated?*_______
Has your current partner ever been identified as the victim or perpetrator in a domestic violence incident by the police, court system or other legal agency?

☐ Yes ☐ No

*If yes, please write an explanation:*_____________
____________________________________________
____________________________________________
____________________________________________

Do you have children together or share in parenting children with your current partner? ☐ Yes ☐ No

Do you have children with or share in parenting children with a previous partner? ☐ Yes ☐ No

*If yes complete the following:*

Length of relationship:_________________________
Age of partner:_______________________________
Name of partner:_____________________________
Why relationship ended?_______________________
____________________________________________
Who ended relationship?_______________________

*Child/Children from that relationship:*
Name(s):______________________________
Age(s):______________________________
Gender(s):______________________________
Live with:______________________________
City & State:______________________________
Who has custody?______________________________
Parenting Plan?______________________________
______________________________

What are two positive aspects of your relationship with the above identified children/adolescents?
1______________________________
______________________________
2.______________________________
______________________________

What are two areas you believe you need improvement in your relationship with the above identified children/adolescents?
1______________________________
______________________________
2.______________________________
______________________________

What is your role in disciplining the children?
______________________________
______________________________
______________________________
______________________________

What types of discipline do you use with the children?
______________________________
______________________________
______________________________
______________________________

**Legal**
Have you been named in any current or past court action involving intimate partners (current or past) and /or children/adolescents?

☐ Yes ☐ No

Have you ever been named or involved with any type of Family Court action involving children/ adolescents in current or past relationships, or outside of your intimate relationships?

☐ Yes ☐ No

Have you ever been named or involved with any type of CPS action involving children/adolescents?

☐ Yes ☐ No

Have you been named or involved with any current or past police action?

☐ Yes ☐ No

Involving intimate partners?

☐ Yes ☐ No

Involving strangers, family, friends or other individuals?

☐ Yes ☐ No

Have you ever been arrested?

☐ Yes ☐ No

*If yes, write a brief explanation. (Include DUI's):*
______________________________
______________________________

Do you have any legal issues pending?

☐ Yes ☐ No

*If yes, please explain:*______________________________
______________________________
______________________________

**Family of Origin**
Were your parents divorced or never married to one another?______________________________
______________________________

List number of siblings, gender and position in family:______________________________
______________________________
______________________________
______________________________

Did your parent(s), other family member, or other caregiver use physical force with any of your siblings or other family members? ☐ Yes ☐ No

*If yes, please explain:*______________________________
______________________________
______________________________
______________________________

Please describe any significant family of origin issues that may contribute to your current distress:
______________________________
______________________________
______________________________

**Career**

Current status: ☐ employed ☐ disability

☐ retired ☐ homemaker

Other:______________________________________

Please give a description of your current career status, including responsibilities:________________

___________________________________________

___________________________________________

___________________________________________

What do you most like and dislike about your current career status?________________________________

___________________________________________

___________________________________________

___________________________________________

**Recreation**

What do you do for fun/recreation?_____________

___________________________________________

___________________________________________

Alone:______________________________________

With Others:_________________________________

How often do you engage in these activities?_____

___________________________________________

**Educational Background**

Please list your educational and/or training accomplishments:_____________________________

___________________________________________

___________________________________________

Have you ever been diagnosed with a learning disability? ☐ Yes ☐ No

*If yes, what was the disability?*_________________

What was the most difficult for you during your educational and/or training experiences?__________

___________________________________________

**SIGNATURE** (*of self, parent, or guardian*)

___________________________________________

**DATE**:________/__________/_________