Center For Integrated Well-Being, Inc.

CLIENT INTAKE FORM

Name:_____ Today's Date:_____

Date of Birth: _____ Age: _____

Main reason(s) for obtaining counseling at this time:_____

_____

_____

_____

Results you would like to see from counseling:_____

_____

_____

_____

Previous counseling history

Date	Therapist	What worked/Didn't work?

MEDICATIONS

Name of Medication	Reason Taken

Do you have any health concerns? (Please circle one.) YES NO
If yes, please explain below.

Infectious Diseases: _____

Allergies: _____

Injuries: _____

Weight Concerns: _____

Appetite Concerns: _____

Sleep Concerns: _____

Fatigue: _____

Distress: _____

Feeling Depressed: _____

Feeling Anxious: _____

Other Health Concerns: _____

Hospitalizations:

Date of Hospitalization	Reason

Are you currently considering harm to yourself? (Please circle one.) YES NO
If yes, please explain below.

Are you currently considering harm to others? (Please circle one.) YES NO
If yes, please explain below.

Are you currently being abused physically or sexually? (Please circle one.) YES NO
If yes, please explain below.

Chemical Use: (Please circle one.) Yes No
If yes, please explain below.

Use of Alcohol: _____

Use of Drugs: _____

Use of Caffeine: _____

Use of Tobacco: _____

Do you exercise? (Please circle one.) Yes No

Please describe: _____

Are you currently involved in any way with the legal system? (Please circle one.) Yes No

If yes, please describe: _____

Are you currently experiencing financial difficulties? (Please circle one.) Yes No

If yes, please describe: _____

Ethnic/Cultural Identity: How do you identify yourself ethnically and culturally?

Please list hobbies and interests and approximately how often you participate in each:

EDUCATION

☐ Did not graduate high school ☐ High school graduate ☐ GED

☐ Some college (years: ____) ☐ Vocational school in _____

☐ BA in _____ ☐ M.A. in _____ ☐ Ph. D. in _____

EMPLOYMENT

Occupation/field: _____

Current employment, work from home or unemployed:_____

FAMILY HISTORY

Parents (please circle one): Married Divorced Deceased

Siblings:

Please indicate whether any of your family members has a mental health, alcohol, chemical issue:

Family Member	Issue

Any abuse in family? (Please circle one.) YES NO

What kind of abuse? (Please circle.) Physical Sexual Emotional/Psychological

Please explain: _____

_____

Questions You May have for Jeffry?_____

_____