Maggie Roney
COUNSELOR, MS, NCC, LPC

Intake Form

Client Information

Client Name: _____ Date: _____
First Middle Last

Form completed by (if someone other than client): _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male ☐ Other: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Work: _____ Ext: _____ Cell: _____

Email: _____

Reasons for seeking services (check all that apply, **CIRCLE PRIMARY REASON**):

☐ Anger Management	☐ Anxiety	☐ Coping	☐ Eating Disorder
☐ Fear/Phobias	☐ Mental Confusion	☐ Sexual Concerns	☐ Sleeping Problems
☐ Addictive Behaviors	☐ Alcohol/Drugs	☐ Marriage Concerns	☐ PTSD

☐ Other Mental Health Concerns (specify): _____

Family Information

Relationship	Name	Age	Living	Living with You
Mother			☐ Yes ☐ No	☐ Yes ☐ No
Father			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No
Child			☐ Yes ☐ No	☐ Yes ☐ No

Significant Others (e.g. brothers, sisters, grandparents, step-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with You
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

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Marital Status

☐ Single ☐ Unmarried, Living Together Length of Time: _____ ☐ Married Length of Time: _____
☐ Separated Length of Time: _____ ☐ Divorce in Process Length of Time: _____
☐ Divorced Length of Time: _____ ☐ Widowed Length of Time: _____
Assessment of current relationship (if applicable): ☐ Good ☐ Fair ☐ Poor

Parental Information

☐ Parents legally married ☐ Have parents ever been separated ☐ Have parents ever been divorced
☐ Mother Remarried Number of Times: _____ ☐ Father Remarried Number of Times: _____

Any special circumstances (e.g., raised by person other than parents, information about spouse, other children living with client, etc.): _____

Development

Are there any unusual or traumatic circumstances that affected your development? ☐ Yes ☐ No

If yes, please describe: _____

_____

Has there been a history of child abuse? ☐ Yes ☐ No

If yes, which type(s): ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional/Psychological

If yes, the abuse was as a: ☐ Victim ☐ Perpetrator

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Other (please specify): _____

_____

Any further comments about childhood development: _____

_____

Social Relationships

How do you generally get along with other people (check all that apply)?

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/Argue Often ☐ Follower
☐ Friendly ☐ Leader ☐ Outgoing ☐ Shy/Withdrawn ☐ Submissive
☐ Other (specify): _____

Sexual Orientation: _____ Comments: _____

Sexual Dysfunctions: ☐ Yes ☐ No If yes, please describe: _____

Any current or history of being a sexual perpetrator? ☐ Yes ☐ No

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Spiritual/Religious

How important to you are spiritual matters? ☐ Not at All ☐ Little ☐ Moderate ☐ Very

Is the family affiliated with a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: _____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No

If yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐ Yes ☐ No

If yes, describe: _____

Legal

Current Status

Are you involved in any active legal cases (e.g. traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, please describe: _____

History

Traffic Violations: ☐ Yes ☐ No DWI, DUI: ☐ Yes ☐ No

Criminal Involvement: ☐ Yes ☐ No Civil Involvement: ☐ Yes ☐ No

If you responded yes to any of the above, please fill in the following information

Charges	Date	Where (City)	Results

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Education

Years of Education: _____ Currently enrolled in school? ☐ Yes ☐ No

☐ High School		Grad/GED: ☐ Yes ☐ No	
☐ Vocational	Number of Years: _____	Graduated: ☐ Yes ☐ No	Field: _____
☐ College	Number of Years: _____	Graduated: ☐ Yes ☐ No	Major: _____
☐ Graduate	Number of Years: _____	Graduated: ☐ Yes ☐ No	Major: _____

Other Training: _____

Employment

Are you currently employed? ☐ Yes ☐ No

☐ Full Time ☐ Part Time ☐ Temp ☐ Laid off ☐ Retired ☐ Disabled ☐ Social Security ☐ Student

Other (describe): _____

Military

Military Experience? ☐ Yes ☐ No Combat Experience? ☐ Yes ☐ No

Where: _____

Branch: _____ Discharge Date: _____

Date Enlisted: _____ Final Rank: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, reading, walking, sports, exercising, fishing, etc.):

Activity	How often now?	How often in the past?

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Medical/Physical Health

- ☐ AIDS
- ☐ Diarrhea
- ☐ Neurological Disorders
- ☐ Alcohol Abuse
- ☐ Dizziness
- ☐ Nose Bleeds
- ☐ Abdominal Pain
- ☐ Drug Abuse
- ☐ High Blood Pressure
- ☐ Abortion
- ☐ Eating Problems
- ☐ Menstrual Problems
- ☐ Allergies
- ☐ Epilepsy
- ☐ Sexual Problems
- ☐ Bed Wetting
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Fainting
- ☐ Sleeping Disorders
- ☐ Chronic Pain
- ☐ Fatigue
- ☐ Vomiting
- ☐ Colds/Coughs
- ☐ Frequent Urination
- ☐ Asthma
- ☐ Constipation
- ☐ Headaches
- ☐ Diabetes
- ☐ Arthritis
- ☐ Sexual Transmitted Diseases
- ☐ Other (Please explain below)

List any current health concerns: _____

_____

Current Medications (please list):

Medication	Dose	Purpose	Side effect

Is child/client allergic to any drugs? ☐ Yes ☐ No If yes, list drugs: _____

_____

Prescribing Psychiatrist/Doctor Contact Information

Name: _____ Phone: _____

Chemical Use History

Substance	Method & Amount	Frequency	Age of First Use	Age of Last Use	Used in Last 48 Hours		Used in Last 30 Days	
Alcohol					☐ Yes	☐ No	☐ Yes	☐ No
Barbiturates					☐ Yes	☐ No	☐ Yes	☐ No
Valium/Librium					☐ Yes	☐ No	☐ Yes	☐ No
Cocaine/Crack					☐ Yes	☐ No	☐ Yes	☐ No
Heroin/Opiates					☐ Yes	☐ No	☐ Yes	☐ No
Marijuana					☐ Yes	☐ No	☐ Yes	☐ No
PCP					☐ Yes	☐ No	☐ Yes	☐ No
LSD					☐ Yes	☐ No	☐ Yes	☐ No
Mescaline					☐ Yes	☐ No	☐ Yes	☐ No
Inhalants					☐ Yes	☐ No	☐ Yes	☐ No
Caffeine					☐ Yes	☐ No	☐ Yes	☐ No
Nicotine					☐ Yes	☐ No	☐ Yes	☐ No
Over the Counter					☐ Yes	☐ No	☐ Yes	☐ No

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Chemical Use History (continued)

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

Describe how your use has affected family or friends: _____

_____

Reasons for use (check all that apply):

☐ Addicted ☐ Build Confidence ☐ Escape ☐ Self Medication

☐ Socialization ☐ Taste ☐ Other: _____

Who or what has helped you in stopping or limiting use? _____

Does/has someone in your family (present or past) have or had a problem with drugs or alcohol?
☐ Yes ☐ No If yes, describe: _____

Have you had withdrawal symptoms when trying to stop the use of alcohol or drugs in the past?
☐ Yes ☐ No If yes, please describe: _____

Counseling/Prior Treatment History

Have you ever had counseling before? ☐ Yes ☐ No

If yes, describe when and the experience: _____

_____

Have you ever had suicidal thoughts or attempted suicide before? ☐ Yes ☐ No

If yes, describe: _____

Do you feel suicidal at this time? ☐ Yes ☐ No

If yes, explain: _____

_____

Have you ever been hospitalized in a drug or alcohol treatment program before? ☐ Yes ☐ No

If yes, describe: _____

Have you ever been hospitalized for psychiatric or mental care before? ☐ Yes ☐ No

If yes, describe: _____

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Counseling/Prior Treatment History (continued)

Behaviors that occur more often than you would like them to take place (check all that apply):

☐ Aggression	☐ Self-Esteem Issues	☐ Drug Dependence	☐ Alcohol Dependence
☐ Cyber Addiction	☐ Eating Disorder	☐ Anger	☐ Depression
☐ Elevated Mood	☐ Antisocial Behavior	☐ Disorientation	☐ Fatigue
☐ Anxiety	☐ Distractibility	☐ Gambling	☐ Avoiding People
☐ Dizziness	☐ Hallucinations	☐ Heart Palpitations	☐ Memory Impairment
☐ Sleeping Problems	☐ High Blood Pressure	☐ Body Image Issues	☐ Mood Shifts
☐ Speech Problems	☐ Hopelessness	☐ Panic Attacks	☐ Suicidal Thoughts
☐ Impulsivity	☐ Phobias/Fears	☐ Thoughts Disorganized	☐ Irritability
☐ Recurring Thoughts	☐ Trembling	☐ Judgment Errors	☐ Sexual Addiction
☐ Withdrawing	☐ Loneliness	☐ Self Injury	☐ Worrying
☐ Sexual Difficulties	☐ Other: _____		

Briefly discuss how the above symptoms has led you to seek help and when these problems began.

Any additional information that would assist us in this therapeutic process?

What are your goals for therapy?

For Staff Use

Therapist's Signature_____ Date: _____