# Intake Form
# Lauren Holmgren Counseling

## Confidential Client Information

Identifying Information (Adult):

Client's Name: ___________________________________________ First Appt. Date: _______
Gender: M ___ F ___ Age: ___ Birth Date: _______ Soc. Sec. # ____________
Drivers License: _________
Home Address: ____________________________________ City/State: ______________
Zip: ___________
Home Tele: _________________ Work Tele: __________________ OK to leave messages at both? _______
Will anyone else be attending counseling with you? If so, who?
_____________________________________
Others living in the home:

NAME AGE RELATIONSHIP TO CLIENT

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

High School College Technical 1Graduate
Education: 1-2-3-4-5-6-7-8-9-10-11-12 13-14-15-16 Y/N Degree: _____
Emergency Contact:
________________________________________________________________________
Name Relationship Telephone

Your Employer: __________________________Occupation:___________________________
How long at current job: _______________ Military History if any: ________________________
Marital Status: _____________________ Spouse/Partner's Name: _______________________
Age: _____
Referred By:
_____________________________________________________________________________
Do you give me your permission to thank the person who referred you? No other information would be disclosed without a specific signed release. Yes ___ No ____

Presenting Problem

Please describe the problem(s) that brought you here and when it began to negatively affect you.

How have the problems your dealing with affected you in the following areas (please check):
Work/study: ___ No impact ____ Moderate Impact ____ Significant Impact
Physical health: ___ No Impact ____ Moderate Impact ____ Significant Impact
Family: ___ No impact ____ Moderate Impact ____ Significant Impact
Social: ___ No impact ____ Moderate Impact ____ Significant Impact
What have you tried to resolve the problem?
________________________________________________________________________________
________________________________________________________________________________
How will you know if counseling has been successful?
________________________________________________________________________________
________________________________________________________________________________
Please list your top goals for counseling:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

COUNSELING HISTORY

Have you ever been in counseling before? Yes ____ No ____
If Yes, how many times ________
Have you ever been hospitalized for psychological or emotional problems? Yes ____ No _____
If Yes, how many times ________

If Yes to either question above, please describe your experience(s) below beginning with the most recent previous episode of treatment.

Treatment Episode:
When did you see the counselor (your age or dates): _____________________________________
Who did you see: _________________________________________________________________
Did you go alone or with others? _____________________________________________________
What problems were addressed? _____________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
What did you like or gain from the experience? ________________________________________
What did you not like about it? ______________________________________________________

Treatment Episode:
When did you see the counselor (your age or dates): _____________________________________
Who did you see: _________________________________________________________________
Did you go alone or with others? _____________________________________________________
What problems were addressed? _____________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
What did you like or gain from the experience? ________________________________________
What did you not like about it? ______________________________________________________

Treatment Episode:
When did you see the counselor (your age or dates): _____________________________________
Who did you see: _________________________________________________________________

Did you go alone or with others? ____________________________________________________
What problems were addressed? _____________________________________________________
________________________________________________________________________________
________________________________________________________________________________
What did you like or gain from the experience? _______________________________________
What did you not like about it? _____________________________________________________
(Please use an additional page if you have other past counseling experiences to report.)

FAMILY BACKGROUND

Where did you grow up and who did you live with?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
How would you describe your childhood?
________________________________________________________________________________
________________________________________________________________________________
What problems did your family have? What strengths?
________________________________________________________________________________
________________________________________________________________________________
Who are you closest to today?
________________________________________________________________________________
________________________________________________________________________________
Please describe any family history (past or present)of psychological or emotional problems.
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

MEDICAL INFORMATION

Have you seen a doctor in the last year? Yes ____ No ____
If Yes, for what problems? ___________________________________________________________
________________________________________________________________________________
Who is your Primary Doctor? ______________________ Doctor!s phone: __________________
Please list any medications you are taking now including dosage and frequency:
________________________________________________________________________________
________________________________________________________________________________
Do you have any allergies? Yes ____ No _____
Have you ever been treated in a hospital?
If Yes, for what problems? ___________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Have you ever been in an accident or suffered any kind of physical/emotional/sexual trauma?
Yes ___ No ____
Please give brief description of kind of trauma and when it happened: ______________________
________________________________________________________________________________
What kind of treatment did you receive, if any? _______________________________________
Have you ever had a head injury? Yes ____ No _____
Other serious medical conditions past or present:
________________________________________________________________________________
________________________________________________________________________________

SUBSTANCE USE HISTORY

Do you use/have you used alcohol? ____ Current ____ Past ____ No
Alcohol Frequency:

____ Never____ Less than 1 time/month ____ 1-4 times/month ____ 2-3 times/week ____Daily

Usual Alcohol Consumption:

____None ____ 1-2 drinks per sitting ____ 3-4 drinks/sitting ____ 5 or more drinks per sitting

Intoxication Frequency:
____Never ____ Less than 1 time/month ____1-4 times/month ____ 2-3 times/week ____ Daily

Other Substance Use: (Check all used in past 6 months)
___None ___Marijuana ___Sedatives ___Stimulants (speed, crank, etc) ___Cocaine ___Inhalents
___Opiates ___Hallucinogens (LSD, Ecstasy) ___Prescription Drugs
Caffeine (number of cups/day) _________
Tobacco (number of cigarettes/day) _______

Alcohol or other drug related problems (Check all experienced in last 6 months):
___Binges ___Job Problems ___Sleep Disturbances ___Physical Withdrawal
___Hangover ___Legal Problems ___Blackouts/memory lapse ___Medical Concerns
___Seizures ___Problems with Friends/Family ___Assaults ___Changes in Tolerance
___Inability to stop after first drink/use ___Passing Out ___Concern over use

History of Substance Abuse Treatment:
____None _____Stopped on own ______Attended AA/other 12-step program
____Attended In-patient _____Attended Out-patient _____Attended community based program

Please describe treatment received and outcome:
_____________________________________________________________________________
_____________________________________________________________________________
Please describe any family substance abuse history:
_____________________________________________________________________________
_____________________________________________________________________________
Other impulsive/addictive concerns:
____ Problem gambling ______ Impulsive spending/shopping _______ Pornography
_____ Internet Surfing ______ Excessive Television viewing _______Impulsive eating

COORDINATION WITH OTHER SERVICES:

Please indicate if there are other agencies/service providers you are currently working with:
Other Mental Health Provider: ________________ Attorney: ___________________________
Physician: _________________________ Juvenile Dept.: ________________________
Corrections: ______________________ Child Protective Services: _______________
Career Counselor: _________________ Employee Assistance Program: ___________