Catalyst Coaching and Counseling

# CLIENT INTAKE FORM

***All information is completely confidential.***

Personal Information Today's date_____

Name:_____

(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age:____ Gender: □ Male □ Female

Marital Status: □ Never married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children:____ Ages:_____

Current Address:

_____

_____

Home Phone:_____ May I leave a message? □ Yes □ No

Cell/other:_____ May I leave a message? □ Yes □ No

Email:_____ May I email you? □ Yes □ No

Referred by:_____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No

Reason for change:

_____

Have you received psychological services, professional counseling, psychiatric services, or any other mental health services in the past? □ Yes □ No Dates of service:_____

Have you ever been prescribed a psychiatric prescription medication? □ Yes □ No

If yes, please list:

1._____Side effects:_____

2._____Side effects:_____

## General Health and Mental Health Information

How is your physical health at the present time?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____

_____

Please list all medications you are currently taking:

1._____Side effects:_____

2._____Side effects:_____

3._____Side effects:_____

Are you having any problems with your sleep habits? □ Yes □ No

If yes: □ Sleep too much □ Sleep too little □ Poor quality □ Disturbing dreams

Other:_____

How many hours of sleep do you average a night? _____

How many times per week do you exercise? _____days _____minutes/hours

What is your choice of exercise? _____

Are there any changes or difficulties with your eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced a weight change in the last two months? □ Yes □ No

Have you been diagnosed with an Eating Disorder? □ Yes □ No

If yes, what is the diagnosis?_____

Do you consume alcohol regularly? □ Yes □ No

How much per day? _____

In one month, how many times do you have 4 or more drinks in a 24-hour period?_____

Do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Rarely □ Never

If yes, what substance are you taking? _____

Have you felt depressed recently? □ Yes □ No

If yes, for how long?_____

List your symptoms of depression. _____

Have you had any suicidal thoughts recently? □ Yes □ No

If yes: □ Frequently □ Sometimes □ Rarely

Have you had suicidal thoughts in your past? □ Yes □ No
If yes, how long ago?_____ How often? □ Frequently □ Sometimes □ Rarely
Have you ever made plans to commit suicide? □ Yes □ No
Do you engage in any form of self-harm? □ Yes □ No
If yes, please list _____

Are you currently in a romantic relationship? □ Yes □ No
If yes, how long have you been in this relationship? _____
On a scale from 1-10, how would you rate the quality of your relationship (10 being great)? _____
How would you describe the relationship? _____
_____

In the last year, have you had any major life changes (e.g. new job, new home, illness, relationship change, loss, etc.)?

_____

_____

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What important things about you, your marriage or family, would be helpful for me, your counselor, to know (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)?

_____

_____

## Quick Check (continued on next page)

Check the boxes of the symptoms you have experienced.

| | | | |
|---|---|---|---|
| □ Extreme depressed mood | □ Mood swings | □ Rapid speech | □ Extreme anxiety |
| □ Panic attacks | □ Phobias | □ Disturbed sleep | □ Hallucinations |
| □ Repetitive thoughts | □ Anxiety | □ Time loss | □ Repetitive behaviors |
| □ Homicidal thoughts | □ Suicide attempts | □ Trouble planning | □ Relationship trouble |
| □ Aggression | □ Anger | □ Addictive Behavior | □ Anhedonia |
| □ Bereavement | □ Dissociation | □ Hopelessness | □ Helplessness |
| □ PTSD | □ Pornography | □ Sexual Addiction | □ Tearful |
| □ Worry | □ Sexual Concerns | □ Bingeing | □ Purging |
| □ Restricting Intake | □ Depression | □ Impulsiveness | □ Compulsions |
| □ Memory lapse | □ Alcohol and/or substance abuse | | □ Eating disorder |

Have you been abused sexually, emotionally or physically? Please describe briefly.

_____

_____

Are you now, or have you ever been involved in any sexual behaviors which have been problematic for yourself or someone else? □ Yes □ No

If yes, please explain:

_____

## Occupational Information

Are you currently employed? □ Yes □ No

If yes, who is your employer? _____, Position_____

Are you happy in your current position? □ Yes □ No

Are you fulfilled in your current position? □ Yes □ No

Does your work make you stressed? □ Yes □ No

If yes, what are your work-related stressors?

_____

When do you rest and please describe: _____

## Religious/Spiritual Information

Do you consider yourself a spiritual person? ___ Yes ___ No ___ Uncertain

My religious preference is: ___ Christian ___ Jewish ___ Agnostic (not sure about existence of God) ___ Catholic ___ Atheist (do not believe in the existence of God) ___ Orthodox ___ Other

Very often spirituality can be an important part of healing. While it is not necessary would you:

Be comfortable to have prayer during counseling? ___ Yes ___ No ___ Occasionally

Be comfortable with meditation during counseling? ___ Yes ___ No ___ Occasionally

Be comfortable with Bible verses during counseling? ___ Yes ___ No ___ Occasionally

How often do you attend a place of worship? _____

How important are matters of faith in your life? _____

## Family of Origin History

Father's Name: _____ Living? __Yes __ No (If yes) Age: _____
Occupation: _____ Health: _____
If Deceased – His age at death: _____ Your age at his Death: _____
Describe Relationship: _____

Mother's Name: _____ Living? ___ Yes ___ No (if yes) Age: _____
Occupation: _____ Health: _____
If Deceased – Her age at death: _____ Your age at her Death: _____
Describe Relationship: _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? #_____
Brother/Sister: _____ Age: _____ Married: Y / N Children? #_____
Brother/Sister: _____ Age: _____ Married: Y / N Children? #_____
Brother/Sister: _____ Age: _____ Married: Y / N Children? #_____
Brother/Sister: _____ Age: _____ Married: Y / N Children? #_____

Check any of the following that applied in your family during your childhood/youth:
__ Family Problems __ Separation __ Divorce __ Affairs __ Alcohol Abuse __ Drug Abuse
__Verbal Abuse _ Sexual Abuse __ Physical Abuse __ School Problems __ Emotional Problems
__ Medical Illness __ Eating Disorder __ Death __ Suicide __ Legal Troubles

Describe family atmosphere while growing up by circling most accurate:

| | | | | |
|---|---|---|---|---|
| affectionate | angry | cold | rigid | cooperative |
| supportive | neglectful | distant | frightening | overprotective |
| trusting | competitive | close | stable | accepting |
| loving | abusive | chaotic | nurturing | expressive |

Other:

_____

How did your family express care and affection?

_____

_____

How did your family express anger and manage conflict:

_____

_____

How did your family manage anxiety and stress:

_____

_____

## Family Mental Health History

The following is to provide information about your family history. Please, mark each as yes or no. If yes, please indicate the family member affected.

| *Issue* | | | *Family Member* |
|---|---|---|---|
| Depression | □ Yes | □ No | _____ |
| Anxiety Disorder | □ Yes | □ No | _____ |
| Bipolar Disorder | □ Yes | □ No | _____ |
| Panic Attacks | □ Yes | □ No | _____ |
| Alcohol/Substance Abuse | □ Yes | □ No | _____ |
| Eating Disorder | □ Yes | □ No | _____ |
| Learning Disability | □ Yes | □ No | _____ |
| Trauma History | □ Yes | □ No | _____ |
| Domestic Violence | □ Yes | □ No | _____ |
| Obesity | □ Yes | □ No | _____ |
| Obsessive Compulsive Behavior | □ Yes | □ No | _____ |
| Schizophrenia | □ Yes | □ No | _____ |
| Addiction | □ Yes | □ No | _____ |
| Other | □ Yes | □ No | _____ |

## Other Information

List your strengths/what you like most about yourself.

_____

_____

List areas you feel you need to develop.

_____

_____

What brings you in today?

_____

_____

What are your goals for therapy? What are you hoping will change by participating in counseling?

_____

_____

Catalyst Coaching and Counseling
Justin Der, MA, M. Div, LPC

Credit Card on File Authorization

Please complete this form if you would like me to keep your credit card information on file for future charges. The use of this form is optional and for your convenience. By utilizing this service it does not take up valuable session time to complete credit/debit card transactions. You may elect to provide payment information with each charge if you do not wish to keep your credit card on file.

Information to be completed by card holder:

Card Holder Name: _____

Card Number_____

Card Type: (circle one) Visa MasterCard Discover American Express

Expiration Date: _____

Security Code: _____ (3 digit code on the front or back of your card)

Billing Address and Zip Code: _____

Phone: _____

Email: _____

Would you like for me to send you a receipt by text or by email? _____

I, _____, authorize Catalyst Coaching and Counseling to charge the above credit card account for psychotherapy services. I agree to update any information regarding this account. The above information is complete and correct

_____

Cardholder Signature Date