Apple Tree Counseling LLC

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Client Intake Form

Name: _____ DOB: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Preferred Phone: _____

Email: _____ Referred By: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Permission to Call: ☐ Yes ☐ No Restrictions: _____

Marital Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed ☐Other _____

Race/Ethnicity: ☐Hispanic/Latino ☐African American/Black/African/Caribbean ☐Asian/Pacific Islander ☐Caucasian ☐Native American ☐No Disclosure ☐Other _____

Gender: ☐Male ☐Female ☐No Disclosure ☐Other _____

Previous Diagnosis: _____

_____

_____

Medications: _____

_____

Primary Care Provider: _____ Phone: _____

Last Physical: _____ Allergies: _____

Medical Diagnosis/Illnesses/Surgeries:

Pregnancy History: #Live Births _____ #Stillbirths _____ #Miscarriages _____

Experienced the Loss of a Child _____

Nutrition Concerns:
Purge ☐Yes ☐No
Restrict ☐Yes ☐No
Overeat ☐Yes ☐No
Binge ☐Yes ☐No

Experiencing Pain: ☐Yes ☐No
Location of Pain: _____
How Long: _____
Medication for Pain: _____
Pain Level Today: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐+

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Immediate Family Members of Client:

Name	Gender	Age	Relationship to Client	Living with Client
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Family Mental Health History:

	Mother	Father	Sister	Brother	Child	Other
Depression	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	☐	☐	
Schizophrenia	☐	☐	☐	☐	☐	
ADHD / ADD	☐	☐	☐	☐	☐	
Trauma History	☐	☐	☐	☐	☐	
Abusive Behavior	☐	☐	☐	☐	☐	
Alcohol Abuse	☐	☐	☐	☐	☐	
Drug Abuse	☐	☐	☐	☐	☐	
Suicide	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	

Physical Symptoms:

- ☐ Headaches
- ☐ Muscle Tension
- ☐ Chest Pains
- ☐ Numbness
- ☐ Sweating
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Sexual Problems
- ☐ Skin Problems
- ☐ Rapid Heartbeat
- ☐ Trembling/Shaking
- ☐ Joint/Muscle Pain
- ☐ Heat Pounding
- ☐ Diarrhea
- ☐ Fainting
- ☐ Fatigue
- ☐ Vision Changes
- ☐ Blackouts
- ☐ Chills/Hot Flashes
- ☐ Stomach Aches
- ☐ Nausea

Other:

Client Intake Form

Top Three Stressors:

1. _____

2. _____

3. _____

Mood (Past 1-2 Weeks):

- ☐ Calm
- ☐ Happy
- ☐ Sad
- ☐ Angry
- ☐ Anxious
- ☐ Frustrated
- ☐ Worried
- ☐ Hopeless
- ☐ Helpless
- ☐ Excited
- ☐ Other _____

Behavioral Symptoms (Past Month):

- ☐ Sleep
- ☐ Enjoying Life
- ☐ Motivation
- ☐ Shame
- ☐ Guilt
- ☐ Concentration
- ☐ Racing Thoughts
- ☐ Loss of Sex Drive
- ☐ Impulsiveness
- ☐ Fatigue
- ☐ Poor Judgment
- ☐ Appetite Change
- ☐ Periods of High/Low
- ☐ Strange Thoughts
- ☐ Strange Behavior
- ☐ Low Energy
- ☐ Anxious
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Notes:

Risk Assessment:

	Yes	No	Today	Recently	Comment
Been so distressed you seriously wished to end your life?	☐	☐	☐	☐	
Do you have a specific plan how you would kill yourself?	☐	☐	☐	☐	
Do you have access to weapons/means of hurting self?	☐	☐	☐	☐	
Have you made a serious suicide attempt?	☐	☐	☐	☐	
Have you purposely done something to hurt yourself?	☐	☐	☐	☐	
Have you heard voices telling you to hurt yourself?	☐	☐	☐	☐	
Relatives who attempted or committed suicide?	☐	☐	☐	☐	
Thoughts of killing or seriously hurting someone?	☐	☐	☐	☐	
Heard voices telling you to hurt others?	☐	☐	☐	☐	

Any hospitalizations for mental health purposes? ☐ Yes ☐ No

If yes, when and for what reason? _____

Have you had any previous counseling? ☐ Yes ☐ No

If yes, with whom and when? _____

Social History:

Are your parents divorced? ☐ Yes ☐ No

Briefly describe your childhood (happy, chaotic, troubled):

_____

Are childhood events contributing to current problems? ☐ Yes ☐ No

Have you experienced any abuse (physical, sexual, verbal)? ☐ Yes ☐ No

How satisfied are you with your current family life? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with the support received from family and friends? ☐ Satisfied ☐ Unsatisfied

How satisfied are you with your quality of life? ☐ Satisfied ☐ Unsatisfied

Do you enjoy leisure/recreational actives? ☐ Yes ☐ No

Are you Spiritual? ☐ Yes ☐ No If yes, importance to you? _____

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Education/Work History:

Years of Education? _____ Degree(s) _____

Work Info: ----

How many jobs held? _____ Been Fired? ☐ Yes ☐ No

Do you have performance problems or difficulties with boss? ☐ Yes ☐ No

How satisfied are you with your current occupation? ☐ Satisfied ☐ Unsatisfied

Substance Use/Abuse:

	Yes	No	Past	Currently
Regularly use alcohol (more than twice a week)?	☐	☐	☐	☐
Had trouble (legal/family/work) because of alcohol?	☐	☐	☐	☐
Felt you should cut down on drinking?	☐	☐	☐	☐
Felt bad or guilty about your drinking?	☐	☐	☐	☐
Ever had a drink first thing in the morning?	☐	☐	☐	☐
Use medications not prescribed to you?	☐	☐	☐	☐
Taken more than the recommended daily dose?	☐	☐	☐	☐
Used any product or other means to get "high"?	☐	☐	☐	☐

Habits:

Do you smoke or chew tobacco regularly? ☐ Yes ☐ No If so, how much? _____

Do you drink caffeinated drinks regularly? ☐ Yes ☐ No If so, how much? _____

Do you exercise on a regular basis? ☐ Yes ☐ No If so, how much? _____

Do you have problems with gambling? ☐ Yes ☐ No

Do you have other potentially harmful habits you want to change? ☐ Yes ☐ No

Describe _____

Reason for Seeking Therapy:

Goals for Therapy:

1. _____
2. _____
3. _____

_____ _____

Client Signature Date

Happy to have you at Apple Tree!