Shady Oak Counseling, LLC
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Client Intake Form

Last Name:		Current Date:	
First Name/MI:		Birth Date:	
Education Level:		Emergency Contact: (Release to be signed)	
Occupation:		Employer & How Long:	
Email:		Cell Phone:	

Medical Information

Primary Care Clinic:		Location/Address:	
Primary Care Physician:		Last Medical Appointment:	
Other Doctors/Therapists: I do NOT have a Primary Care Doctor. ☐	1.	2.	3.

Medical History & Problems:

Hospitalizations for Mental Health: Y ☐ N ☐
If Yes, Please explain, include dates:

Health is rated as:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Please list all medications, dosages & frequency:

Medication	Frequency

Allergies to Medications:
Y ☐ N ☐
If Yes, What Medication(s):

Present During Childhood:

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Brother(s)
- ☐ Sister(s)
- ☐ Other (Specify)

Present Part of Childhood:

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Brother(s)
- ☐ Sister(s)
- ☐ Other (Specify)

NOT Present at all:

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Brother(s)
- ☐ Sister(s)

Parent's Marital Status:

- ☐ Married to Each Other
- ☐ Separated for ____ years
- ☐ Divorced for ____ years
- ☐ Mother remarried ____ times
- ☐ Father remarried ____ times
- ☐ Mother involved with someone
- ☐ Father involved with someone
- ☐ Mother deceased ____ years
- ☐ Father deceased ____ years

Special Circumstances in Childhood Home:

Describe Childhood Family Experience:

- ☐ Outstanding/Supportive
- ☐ Normal
- ☐ Chaotic
- ☐ Witnessed Abuse________________
- ☐ Experienced Abuse________________

Age & circumstances in leaving childhood home:

Please note any familial mental health history:

Do you have any significant losses that have impacted your life?

Relationship History

Discuss any past or current significant issues in intimate relationships:

Discuss any past or significant issues in other immediate family relationships:

Persons Currently in Home:

Name/Age:	Realtionship to Client:

Persons NOT Currently in Home:

Name/Age:	Realtionship to Client:

Relationship Status:	RE: Intimate Relationships:
☐ Single, never married ☐ Partnered _____ mos/yrs ☐ Engaged ____ mos/yrs ☐ Married ____ mos/yrs ☐ Divorced ____ mos/yrs ☐ Divorce in process for ____ mos/yrs ☐ Live-in for ____ mos/yrs ☐ ____Prior marriages- self ☐ ____ Prior marriages- of partner	☐ Never dated ☐ Never in a relationship ☐ Not currently in a relationship ☐ Currently in a relationship **Relationship Satisfaction:** ☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied ☐ Dissatisfied ☐ Very dissatisfied

Social History

Describe your support network, extended family connections and friendships and indicate if they are helpful:
Describe your leisure activities/hobbies:
Briefly list past jobs/occupations and length of employment:
Discuss any occupational problems and indicate nature of problem (performance, relational, safety):
Briefly list any legal or court problems and indicate whether past or present:
List any other formal support (social workers, probation officers, faith community connections, etc.):

Current Psychological Symptoms

Check any of the following that you've experienced in the past 3 months:

- ☐ Depressed/Unhappy
- ☐ Difficulty Concentrating
- ☐ Socially Withdrawn
- ☐ Excessive Sleeping
- ☐ Loss of Interest in Usual Activities
- ☐ Tearful/Crying Spells
- ☐ Rituals of Lower Anxiety
- ☐ Confused Thoughts/Feelings
- ☐ Fears/Phobias
- ☐ Work or School Problems
- ☐ Drinking Alcohol in Excess
- ☐ Difficulty Making Decisions
- ☐ Gambling Problems
- ☐ Low Motivation
- ☐ Appetite Change
- ☐ Low Self-Esteem
- ☐ Low Sex Drive
- ☐ Worthless
- ☐ Hopelessness
- ☐ Suicidal Thoughts
- ☐ Self-injurious Behavior
- ☐ Financial Problems
- ☐ Nightmares
- ☐ Guilty
- ☐ Insomnia
- ☐ Racing Thoughts
- ☐ Impulsive/Risk-taking
- ☐ Too Much Energy
- ☐ Excessive Worries
- ☐ Restless (Pacing)
- ☐ Angry Outbursts
- ☐ Legal Trouble
- ☐ Panic Attacks
- ☐ Family Problems
- ☐ Coping with Abuse (Now or in the Past)
- ☐ Tense
- ☐ Social Anxiety
- ☐ Obsessive Thinking
- ☐ Fatigue
- ☐ Anxiety: Past Trauma
- ☐ Feeling "Numb"
- ☐ Flashbacks While Awake
- ☐ Avoiding People
- ☐ Irritable
- ☐ Forgetful
- ☐ Other ___________

Check any of the following physical sensations that often apply:

- ☐ Headaches
- ☐ Tingling
- ☐ Muscle Spasms
- ☐ Muscle Tension
- ☐ Itchy or Burning Skin
- ☐ Dry Mouth
- ☐ Unable to Relax
- ☐ Dizziness
- ☐ Heart Racing
- ☐ Blackouts
- ☐ Flushing
- ☐ Excessive Sweating
- ☐ Chest Pain
- ☐ Fainting Spells
- ☐ Vomiting
- ☐ Stomach Problems
- ☐ Neck/Back Pain
- ☐ Trouble Swallowing
- ☐ Bowel Problems
- ☐ Chronic Pain
- ☐ Hear Things
- ☐ Visual Disturbances
- ☐ Tics/Twitches
- ☐ Odd Sensations
- ☐ Tremors
- ☐ Don't Like Being Touched
- ☐ Sexual Problems

Substance Use History

Substance Used	Age of First Use	Age of Last Use	Currently Y/N	Frequency	Amount
Alcohol					
Amphetamines/Speed					
Barbiturates/Downers					
Cocaine					
Crack Cocaine					
Hallucinogens (LSD)					
Inhalants (Glue, Gas)					
Marijuana/Hashish/Pot					
Nicotine/Cigarettes					
PCP					
Over the Counter Diet					
Over the Counter-Rx's Misused					
Caffeine					

CAGE Assessment: Please indicate which statements apply to you:

- ☐ Have you ever felt the need to CUT DOWN on your drinking and/or drug use?
- ☐ Have you ever been ANNOYED by criticism of your drinking and/or drug use?
- ☐ Have you ever felt GUILTY about drinking and/or drug use?
- ☐ Have you ever felt the need for an EYE-OPENER when you first get to work, or need for alcohol/drugs to keep functioning or to cope with withdrawal symptoms for going to work or a social event?

Check any of the following that may apply:			
☐ Hangovers ☐ Seizures ☐ Blackouts ☐ Overdose	☐ Withdrawal Symptoms ☐ Medical Conditions ☐ Tolerance Changes (Irritation) ☐ Loss of Control	☐ Sleep Disturbance ☐ Assaults ☐ Suicidal Impulse ☐ Relationship Conflicts	☐ Binges ☐ Job Loss ☐ Arrests ☐ Other__________

Substance Use Status:	Treatment History:
☐ No history of use- never used any substances ☐ No history of abuse/dependence ☐ Present and active use. Last date used:_______ ☐ Have NOT used for at least 6 months ☐ Have NOT used for at least 1 year ☐ Have NOT used for at least 2 years	☐ Outpatient- List dates ____________________ ☐ Inpatient- List dates _____________________ ☐ 12-Step Program- List dates ___________________ ☐ Stopped on own- List dates _________________ ☐ Other _________________________________

Closing Questions

Please describe why you have come to seek therapy. How does this impact your daily life?
What do you expect from this therapy experience? How will you know therapy has been successful for you?

By signing this consent, you are agreeing to receive appointment confirmation either via telephone, text, or email. Email will not be used for any other correspondence.

Client Signature:____ **Date:**______________________________

Print Name:____