Hagerstown Counseling, LLC

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Client Intake Form

Client Name: _____ Date of Birth:_____/_____/_____

Age: _____ Race: _____ Sex: _____ Phone: _____

Address: _____ City & Zip Code: _____

Email: _____

Marital Status: _____ No. of Times Married: _____

Children (names and ages): _____

Place of employment and position: _____

Religious/Spiritual Affiliation: _____ No affiliation: _____

Primary Problem (the reason you came to treatment): _____

_____

Symptoms (please check all that apply):

□ Depression	□ Suicide Thoughts/Attempts	□ Over-Confident	□ Crying Episodes
□ Worrying/Anxiety	□ Feeling Hopeless	□ Panic Attacks	□ Fatigue
□ Sleep Problems	□ Weight Changes	□ Eating Disorder	□ Obsessive Thoughts
□ Anger Issues	□ Loss of Interest in Activities	□ Mood Swings	□ Sexual Problems
□ Self-Esteem	□ Aggression/ Violence	□ Harming Self	□ Drug / Alcohol Problem
□ Hallucinations	□ Trouble Concentrating	□ Poor Hygiene	□ Financial Stress

□ Communication Problems □ Other: _____

Medical History:

Current Medications & Dosage: _____

Health Problems: _____

Allergies: _____ Hospitalizations: _____

Previous Mental Health Treatment:

Facility Doctor: In/Outpatient: Dates of Treatment: Reason:

_____ _____ _____ _____

_____ _____ _____ _____

Legal History (Please list any current and previous charges, even if not found guilty.): _____

_____

Childhood/Family History:

List the people who you lived with during your childhood: Relationship to you: _____ Age: _____

_____ _____

_____ _____

Describe your childhood: Wonderful Normal Chaotic Abusive

Significant Childhood Events: _____

Substance Use:

	Age at first use	Date of most recent use	Current amount used
Caffeine (coffee, soda)			
Nicotine (cigarettes)			
Alcohol			
Marijuana			
Cocaine/Crack			
Steroids			
Ecstasy/Hallucinogens			
Heroin			
Barbiturates			
Crystal Meth			
Prescription or "over the counter"			
Other:			

Education History: Highest grade completed: _____ HS Diploma or GED?

Any learning or behavioral problems in school? _____

Currently in School? _____ Future education goals? _____

Military History: Branch of Services: _____ Dates of Service: _____

Ever in combat? _____ Type of discharge: _____

Social/ Hobbies:

Current Hobbies and Interests: _____

Describe your Social Life: Center of Attention Few Friends No Friends Other: _____

Anything else you think I should know? _____

This section is for office use only.

Presentation/Mental Status:

Appearance:	well groomed	unkempt	inappropriate	very poor	
Affect:	appropriate	blunted	flat		
Mood:	euthymic	irritable	depressed	hypomanic	pessimistic
Speech:	fluent	slowed	loud	flight of ideas	mute inconcruent
Thought:	nomal suicidal	homicidal	phobias	hallucinations	preoccupations
Memory:	normal	slowed	difficult	impaired	
Cognition:	orientation x5	distractible	confused	vigilant	scattered
Insight:	normal	impulsive	distorted	denial	paralyzed

Clinical Summary/Impression:

Treatment recommendations: Ind/ Fam sessions _____times per month to address symptoms using _____

_____treatment techniques.

DSM-V Diagnosis:

_____ Date: _____

Jennifer Pierce, MS, LCPC
Licensed Clinical Professional Counselor