Covenant Counseling & Family Resource Center

CLIENT INTAKE PACKET

A thorough assessment is important because it can provide your counselor with helpful information about your background. In an effort to ensure that our counselors can spend time in-session focusing on what is most important to you instead of collecting this information, we ask that you complete this packet and bring it with you to your first appointment.

Name:_____ Today's Date:_____ Address:_____

_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work #:_____ Cell #: _____

Email Address: _____

DOB:_____ Age: _____

May we…

Leave messages at the above phone numbers? ☐YES ☐NO

Send appointment reminders via text message to the above cell number? ☐YES ☐NO

Send appointment reminders to the above email address? ☐YES ☐NO

Contact you via email if we cannot reach you by phone? ☐YES ☐NO

Name and Number of Emergency Contact Person: _____

How did you hear about Covenant Counseling? _____

_____

Briefly describe the issues/problems that led you to counseling today:

_____

_____

What goals would you like to achieve with counseling? _____

_____

_____

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CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues."

- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Housework/chores—quality, schedules, sharing duties
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Parenting, child management, single parenthood
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems (with friends, with relatives, or at work)
- ☐ School problems (see also "Career concerns")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care

- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

_____

_____

Which of the above concerns do you most want help with?

_____

PSYCHOSOCIAL HISTORY

Treatment History

Have you ever participated in counseling, psychotherapy, psychiatric/mental health treatment, or substance abuse treatment? If so, please complete the following information to the best of your ability:

Date(s)	Provider	Purpose/Focus of Treatment	Outcome

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Trauma History

Did you experience any physical, sexual, or emotional/psychological abuse or neglect during childhood or as an adult? If so, please describe:

Have you had any experiences you'd consider to be traumatic (e.g., threat of serious harm/injury, natural disaster, victim of a crime, traumatic losses/deaths, etc.)? If so, please describe:

Family Psychiatric History

Has anyone in your family ever been diagnosed or treated for a mental health disorder or for an alcohol- or drug-related problem? Has anyone had these problems but not been treated? If either apply, please indicate below:

Family Member	Problem/Disorder	Describe Treatment (if any)

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Medical Conditions & History

Do you have any current or recent medical/physical concerns?

☐ No ☐ Yes; Describe: _____

_____

_____

Do you have a primary care physician?
☐ No
☐ Yes; Name of Physician/Practice: _____

Do you have health insurance? ☐ Yes ☐ No

Please describe any history of surgeries, significant medical procedures, or ER visits, or major illnesses (including dates if possible):

_____

_____

_____

Medications (including dosages, prescribing physician, and purpose of medication):

_____

_____

_____

_____

Allergies: _____

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Substance Use

Please enter the following information for any substances including alcohol, tobacco, and drugs that you currently use or have used in the past:

Substance	Past Use? (Yes/No)	Current Use? (Yes/No)	How often/how much in past year?

Family History

Were you adopted? ☐Yes ☐ No

Who lived with you growing up? _____

Did you have brothers or sisters? ☐Yes ☐ No

If so, list their names and ages: _____

Did/do you have stepparents? ☐Yes ☐ No

How would you describe your family growing up? _____

What was your parents' relationship with each other like? _____

What was your relationship with your mother like growing up? _____

What is your relationship with her like now (if living)? _____

What was your relationship with your father like growing up? _____

What is your relationship with him like now (if living)? _____

Did you experience any physical, emotional, or sexual abuse or neglect as a child or as an adult?

☐No ☐Yes Describe: _____

What is your relationship status (check all that apply)? ☐ Single ☐ Married ☐ Dating

☐ Co-habitating ☐ Divorced ☐ Separated ☐Other: _____

Do you have children? ☐No ☐Yes Names andages: _____

Social, Spiritual, & Developmental History

Where were you born? _____

Where did you live growing up? _____

Were there any complications with your birth? _____

Were there any developmental delays growing up? _____

What were your friendships like growing up? _____

Describe your friendships now: _____

Who do you turn to for support? _____

How many serious relationships have you been in your life? _____

Describe your history of romantic relationships: _____

Are you in a relationship now? ☐Yes ☐No If so, for how long? _____

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Describe your relationship with your significant other: _____

_____

Describe your sexual orientation: ☐Heterosexual ☐Homosexual ☐Bisexual

☐ Pansexual ☐Questioning ☐Asexual ☐Other: _____

Describe your religious or spiritual beliefs: _____

_____

Describe any social groups or institutions you are involved in (e.g., clubs, associations, congregations):

_____

_____

What do you do in your spare time? _____

_____

Educational and Vocational History

What was school like for you growing up? _____

What is the highest level of education/highest grade you completed? _____

If you went to college or grade school, what degrees or certifications did you earn?

_____

_____

Describe your employment history: _____

_____

Are you working now? ☐Yes ☐No

What is your occupation?_____Annual income? _____

Describe any vocational/occupational goals you may have for the future: _____

_____

Legal History

Have you ever been arrested? ☐Yes ☐No

If so, when and what charge(s)? _____

_____

_____

Describe any current legal concerns: _____

Other Information

What are your strengths? _____

_____

Anything else you want us to know? _____

_____

_____